

*In This Issue:*

*Excerpts from Experiments in Survival*

October, 1961      Volume XXII, No. 10

# REHABILITATION LITERATURE

National Society for  
Crippled Children and Adults

Review Articles

Book Reviews

Digests

Abstracts

Events and Comments

*Rehabilitation Literature* is intended for use by professional personnel and students in all disciplines concerned with rehabilitation of the handicapped. It is dedicated to the advancement of knowledge and skills and to the encouragement of co-operative efforts by professional members of the rehabilitation team. Goals are to promote communication among workers and to alert each to the literature on development and progress both in his own area of responsibility and in related areas.

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# REHABILITATION LITERATURE

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# REHABILITATION LITERATURE

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## Article of the Month

### From the Book

## Experiments in Survival

Leonard Kriegel's Story

and

A Postscript to Survival

Contributed by  
Leonard Kriegel

### Leonard Kriegel's Story

#### About the Author . . .

*Leonard Kriegel was born in New York City in 1933 and, except for 2 years spent as a patient in the New York State Reconstruction Home in West Haverstraw, has lived there all his life. Mr. Kriegel received his high school education at home and then attended Hunter College, where he received his B.A. in 1955. After earning his M.A. at Columbia University, he went on to receive his Ph.D. at New York University in 1960. He is married and is at present a professor of English at the City College of New York.*

*We are grateful to Dr. Leonard W. Mayo, Executive Director, and to David Klein, Division of Publications, of the Association for the Aid of Crippled Children, for the opportunity to reprint these excerpts from the book.*

ON A HOT, LATE-JULY day in the summer of 1946, I returned to that same Bronx world in which I had spent 11 of the 13 years of my life. It was, as a matter of fact, almost 2 years to the day that I had left. I was driven home in an ambulance, the same ambulance that had once taken me away, from the New York State Reconstruction Home in West Haverstraw. I was changed both in appearance and spirit. The appearance I can give to you with ease—distance furnishes a pliable-enough indifference to physical details. I was fat, hog-fat and baby-soft, tall for a boy just turned 13, 5 feet 5 inches, but almost as wide as tall. My face was oval, a pattern broken only by two heavy, drooping jowls, crowned by a thick blond pompadour, which, if I am not mistaken, was the only stylish aspect of my appearance. I do not remember what I was wearing.

What I do remember is that my father and the ambulance driver carried me out of the ambulance and stood me up on the sidewalk. My father held me up while the driver placed a crutch under each arm. I stood on the sidewalk for several seconds, the still-strange wooden sticks beneath my arms, blinkingly pausing in the midday sun to re-acquaint myself with home. My cousin Leo walked over and stood alongside me, smiling. It was then that I knew that I was home. Leo and I had grown up together. I said goodbye to the driver and began to walk, flanked on one side by my father and on the other by my cousin, the few feet that led from the ambulance to the stone steps leading into the lobby of our apartment house. My neighbors, some of whom had devoutly prayed for my recovery for 2 years, huddled in smiling groups on both sides of the landing, nodding their encouragement to me and to each other. Their fear matched mine, step for step, as I approached the landing, the nine stone steps passively answering my



unvoiced question. I had, of course, known the answer all the way home in the ambulance—I couldn't climb them. I stood there, staring at the stairs, hating them not for having defeated me but for having done it so publicly, feeling my mother's lip-biting tension from the second-story window of our apartment, even though I couldn't see her because I was afraid to look up. It was more than the remorse caused by that first public defeat. It was the recognition of my guilt, of what I had done *to them*, to my mother and father and to all those others who had shared at least a sense of my agony if not the pain that went with it. Ashamed to look at my mother, ashamed to look at my father, ashamed even to speak, I stood there and stared down at the steps, trying to work up enough anger and hatred so that I could show my shame with tears. But the tears, like so much else that day, didn't come.

I bit into my lip, a gesture of public contrition. Finally, I looked at my father, "I can't," I said, shaking my head. "I'm sorry. But I can't."

My father nodded. "You'll walk up some other time," he said, his voice peculiarly flat. "You'll learn." Again he nodded, only this time as if to convince himself. "You'll learn," he repeated. "Won't he learn, Leo?"

My cousin was standing behind me, so I couldn't see him when he answered. "Sure," I heard him say, "sure, he'll learn."

Then my father put his right arm under my right leg, the other arm under my shoulders, and someone else, I think it was our upstairs neighbor Mr. Golden, put his left arm under my left leg, his right arm around my shoulders. They lifted me, basket style, and carried me up the stairs. Leo followed with the crutches.

It took me 2 or 3 months to learn how to walk up those stairs. Until then, I would sit on the bottom step and boost myself up with my arms, while my brother or my mother or one of my friends held my legs high in the air. But my father was only partially correct. It was not really I who learned. It was my body. It already knew, instinctively, I suppose, that the arms could do some of the things for which legs had been made. And then it found out that even the legs could learn how ingenuity can sometimes take the place of muscle.

And that was the way it was for the next 4 years. My body made the moves. It adjusted. It came to know its enemies—the curbstone that was just a half inch or so too high to take on the swing-through gait, the dry leaf or piece of paper lying carelessly in the street, waiting for my crutch like a booby trap, the thin sheet of ice that wasn't visible at night unless I walked slowly, eyes searching the pavement beneath me for the secret of balance, the drops of water on a marble hallway or tile

### About This Article...

THIS MONTH the Association for the Aid of Crippled Children, New York, is publishing the book *Experiments in Survival*. Of the 33 autobiographical accounts in the book, we have selected for publication as our Article of the Month, Leonard Kriegel's contribution to the book. His story is followed by his "Postscript," the final section in *Experiments in Survival*, which serves as a commentary on the personal accounts in the book.

#### Experiments in Survival

Compiled and edited by: Edith Henrich; commentary by Leonard Kriegel

1961. Association for the Aid of Crippled Children, 345 E. 46th St., New York 17, N. Y. \$3.50 (30% discount to professional and health organizations ordering 2 or more copies).

The AACC, about a year ago, made a study of the published biographies of handicapped persons. The Association concluded that relatively little of the literature was truly helpful either to handicapped

persons or to persons involved with them professionally or socially. Much of the biography is too sentimental and too unrealistic to communicate accurately and honestly what it is like to be handicapped. Many of the better written accounts are by persons so talented and exceptional that the average person with a handicap is unable to identify with the authors. And too often the author has written a full-length book in which only one or two episodes are significant.

The personal stories in *Experiments in Survival* are honest and forthright, being told by ordinary persons who are willing to admit that they have not solved all their personal problems. Mrs. Henrich, the compiler, is a published poet and teacher of college English. The book is ample evidence of her ability to work with persons who have a story to tell but whose writing skills may be limited. That she began losing her vision some 15 years ago and is now herself handicapped by being nearly blind may have something to do with the fine rapport she achieved with many of the contributors. We commend the book to you and to the persons with handicaps with whom you work.—*The Editor*

## ARTICLE OF THE MONTH

bathroom, and all the other enemies that have been with me for so long now that they are almost friends, more familiar, in fact, than any friend can be.

But the enemy I remember best, the one I still dread most, strangely enough, was the one that I shared with many other adolescents who had no idea of what it was to walk on sticks and steel. And here, I must admit, it is difficult to muster enough indifference to kill the sense of shame. What, after all, can you say about boils?

I suppose you can begin by saying boils have a simplicity all their own. If you walk on braces and crutches, a boil is simply an additional nuisance, one which, if it erupts within the armpit or where the leather straps of a brace meet your leg, confines you to bed. And that's how this next episode began: in bed with boils. It was a month before my 17th birthday and this time there was a boil on each knee, both of them almost ripe but not yet ready to be lanced by our family doctor. My bed was right next to the window. It was only the middle of April, but it was warm enough so that I could keep the window open and look out on what was happening in the street below. My younger brother, Abe, and several of my friends were playing stickball. Their hawking cries floated through the window like languid balloons. It was all very familiar, almost reassuring, since by now I had assumed the role of spectator as if it were to remain permanent and unalterable. It was a comfortable role and, at that time, a necessary one. In bed, I was whatever I wanted to be, transposing the reality of any situation into the fine fabric of my imagination. The sanity of a stickball game in the street below could not really touch me so long as I lived in the Yankee Stadium of my soul.

But there were still the boils. The boils ached, pitting their own reality against that of my imagination. The boils ached, contracting with a meticulous regularity. I watched as my friend, Billy Maloney, stepped up to the manhole cover that served as home plate, dropped the pink rubber ball on the ground, and then caught hold of it with the end of the stick, driving it high and deep until it bounced against the roof of the convent at the far end of the street. The boils continued to throb. Billy trotted across home plate, and, as I watched him, I became Billy, just as I might have become any of the others, just as I frequently became whoever it was necessary for me to become. But this time there were the boils. They ached, throbbing beneath the skin, taut, expectant, waiting for the knife. I tried to ignore them, but I couldn't. It wasn't the pain; there had been far greater pain over the last 6 years. But that had been pain with meaning—a sharp crisis, a cold anxious moment, a sudden stab of summer lightning. And then a sigh of relief, an end to pain, the cold sweat on the forehead that signaled a new beginning. But the boils just throbbed, like a neon sign automatically flashing on and off, on and off, on and off.

And then, as unannounced as violence usually comes, the reality of my imagination dropped away, to die permanently in the sudden burst of anguish and despair that heralded my realization that I would never play ball again. The boils continued to throb, and now it was as if each contraction of pain said to me, "You are a cripple. You are a cripple. You are a cripple." It was the kind of moment that I had never before permitted to invade my consciousness, a moment of total candor. It came with all of the impact of a shock, and yet, unlike a shock, embedded itself permanently within the boundaries of my existence. I *was* a cripple. Not a ballplayer, not a hero, not a lover, not even an adolescent. But a cripple. It was so simple, so brutal, that truth.

My body began to shiver in a paroxysm of self-pity. Outside, the stickball game continued. My brother stood at the manhole cover now, eyeing the pink ball that he had bounced in front of him, bringing the stick around until it met the ball and drove it past the third baseman and against the red brick wall of the apartment house after ours. For the last time, I felt the sharp sting of pleasure just as he felt it, racing from the tips of the fingers into the shoulders. And then the tears came. At first, I wept quietly, filled with self-pity because I could never again be my brother. And then I wept harder, thinking of what *they*, of what all the *theys* in the world, had done to me. I knew that *they* had done it, the *they* of God, the *they* of my mother and father, the *they* of my brother and my friends, of all the doctors and nurses who had lied to me in the hospital, of all those people who came like mendicant saviors into my apartment to lay their sloganized attempts at comfort at my feet. I wept, and, turning away from the open window, I sought solace in the warm safety of the pillow.

I don't know how long I wept—a half hour, an hour, maybe more. Time no longer mattered. Time, too, belonged to their world, the world that had turned so suddenly, so viciously, against me. All I know is that, as I lay face down in the pillow, the tears slowly stopped, the spasms of anguish grew less and less frequent, until I lay there with nothing left but exhaustion and a growing knot of hate in the pit of my stomach. And creeping into my consciousness there came a new resolution. I swore to myself that I would get even with all the *theys* who had done this to me. I would work. I would discard imagination for action. I would mold the fat of my body into muscle, until my body could do whatever I ordered it to do. I would carve from the lifelessness of my legs a new will. And I would show them. Above all, I would show all the *theys*. The hate knotted in my stomach momentarily gave way to a dry, hard rage. I would show them. I would show them all.

The next day the family doctor came and lanced the boils. It was a beginning. I knew now what I had to do, having spent the previous evening examining, not dis-

passionately, but with that cold clarity that is among the most valuable gifts of rage, whatever assets and liabilities I possessed. A plan of action, of self-creation almost, had taken root in my mind. But it was the body, not the mind, to which I turned. My legs were lifeless. I was still as fat as a hog. But like the stone clarity that morning-after sobriety brings to a late-night drunkard, the knowledge of my arms came to me. In the arms, I would mold fat into muscle. To the arms, my will would attach itself. The fingers in my hands I would make into toes as well as fingers, the wrists feet as well as wrists, the forearms calves and forearms, the elbows knees and elbows, the shoulders thighs and shoulders. In the arms lay my salvation.

As soon as I could get out of bed, I began to exercise. For hours at a time, I would exercise—push-ups, sit-ups, lifting weights. Today, the memory of what my body did is somewhat embarrassing. And yet, if I am to keep this memoir honest, I must also confess to a warm pride that floods my very being whenever I think back to those days. The pride is for the way in which my body, especially my arms, responded to the demands I made upon it. I suppose my behavior constituted as good an example of autism as one might wish to find. In a sense, I remained in a world of fantasy. But now the fantasy permeated my every waking moment. Now the fantasy had nothing at all to do with an imaginative second life. All that I wanted was to protect the growing self that I felt within me. I needed to be left alone, to nurture the awakening power of my body, to break through all the old possibilities my imagination had offered me into the promise of selfhood.

I allowed nothing, no one, to violate that embryo of selfhood. I remember one time, lying in a pool of sweat on the linoleum-covered floor of my bedroom, when my mother entered my room, begging me in a tearful, frightened voice to come into the kitchen for dinner. I told her to get out, with all the anger that I could muster against a threat to my new existence. And then I continued my push-ups, the ache in my shoulders growing almost as quickly as the pride in my mind, until I collapsed on the floor, gasping for breath, the salt taste of my own sweat running into my mouth. And for the first time in my life, I knew what was meant by pride in oneself.

The hate carried me. It carried me all through that year. It woke me up in the morning for an hour's exercise before breakfast. It took me through breakfast, then through the hour's home instruction that constituted my only formal schooling from the eighth grade of grammar school until my freshman year in college. It stung me into 2 hours of brutal physical exercise after lunch. It enabled me to go for long walks through the neighborhood on the braces and crutches. It took me home for supper. And from there it sent me to Williamsbridge Oval, a city park and playground, where I spent another 2 or 3 hours on the high bars, my arms pumping for the security my soul demanded.

The fat dropped from my body, 2, 3, 4 pounds a week, like wax dripping from a burning candle. The muscles in my arms, chest, and shoulders took on definition. The jowls disappeared. The upper part of my back grew hard and confident. My wrists and forearms thickened. And then one day, perhaps 6 months after the birth of desire, I stood before a mirror and looked at myself, searching my image as a connoisseur of art might search a Rembrandt. And, momentarily filled with gratitude instead of hate, I began to weep. My body had forged a soul.

**I**t is now more than 10 years since that warm April day a month before my 17th birthday. So many things have changed. The hate has died, perhaps only because there is nothing left to feed it. I still devote 15 or 20 minutes a day to exercise (anyone who walks on his arms learns these not-too-subtle tricks of the trade, even after the first battle has ended), but the thought of once again doing what I then did fills me with a cold sense of awe at a performance that, at this late date, seems somewhat maniacal. The self I sought so desperately is within me now, burned into the substance of my soul. I live, as most of us do, in a house of bread and dreams.

I make my living as a teacher. And despite the proper air of dispassionate professional courtesy with which I listen to the hopes, anguish, and fears of my students, I frequently find myself thinking how all of us fight our lonely wars, reaching for the enviable future we all know we deserve, afraid only of the memory because to remember is to come to terms with the dreams. The process seems to me inevitable. We are, after all, neither heroes nor cowards. Such are the limitations of our humanity.

And then I think of the many times I have been told, by doctors and social workers and other people who specialize in telling one such things, how my life is an excellent example of what the power of the will can do. My own humanity is as limited as anyone else's, and so, I sadly confess, I find such praise rather pleasing. But then, after I have regained the perspective of memory, I once again am forced to admit to myself that these people are wrong, that they simply do not know of what they speak. They speak of courage and will, but survival is never really a question of courage or will. The future is a shadow already scarred by the past. We grope along, blinkers on our minds, matching the pebbles in the country of now with the boulders in the mountain of time past. It is not a question of will or courage. We are none of us Hemingways, not even Hemingway.

Still, I survived. And I am glad that I survived. Because, even if survival itself is dictated by the past, it is an accident of life and not of death. At the beginning of this memoir I wrote that existence itself remains a puzzle to me. Why I survived, I do not claim to know. But I did. All I can do is to salute my body. For it was the body that chose. And the body chose well.



## A Postscript to Survival

By Leonard Kriegel

AS WE POINTED OUT in the Introduction to *Experiments in Survival*, it was our hope that the narratives making up this book would offer the reader a realistic perspective on the problems of the physically handicapped. To that end, we presented the stories of 33 handicapped people, none of whom is outstanding or famous, none of whom has acquired great social prominence or unusual material success. Although several of our contributors are above average in both insight and articulateness, they, too, can be considered average in status.

On the whole, then, our contributors lead what must, for want of a better term, be called "ordinary" lives. Most of them speak of their desire for more adequate schooling, their dissatisfaction with their jobs, their loneliness; all of these are "normal" problems, but our contributors have been forced to meet them with the additional obstacles of being without sight, without mobility, without the use of their arms.

Maintaining a stable family life, to take an obvious example, is a most important problem to any married woman, but a woman like Joan Hardee must meet that problem with certain difficulties that the nonhandicapped woman simply does not have to think of. This is offered as a simple fact, not to create out of Joan Hardee (or any of the other contributors) a stereotype combining the selfless devotion of Florence Nightingale with the passion of Albert Schweitzer; such an attitude is actually belittling, for it demands that Joan Hardee become part of that very artificiality she spends her time fighting; it destroys her equality as a human being by insisting that she be interested, body and soul, in truth, justice, self-sacrifice, and virtue. Above all, it imposes upon her a responsibility to the world at large.

The idea that handicapped persons are somehow inherently more generous than nonhandicapped persons must be dismissed as the kind of sentimentalized, almost mystical, cliché that is so frequently substituted for intensive analysis and thought. Nevertheless, the simple fact that most of our contributors have been so dependent upon others offers a logical basis for the fact that many of them regard the opportunity to help others as among their deepest satisfactions. Let us, however, accept this satisfaction for what it is—an opportunity for the man who has been served to serve. To point this out does not in any way belittle either the generosity or the motivation of our contributors. One could analyze why individuals take up medicine, law, teaching, or plumbing in much the same manner.

Some of our contributors quite obviously were unable to break away from certain public conceptions of what the

handicapped individual is. Some were enervated by a creed that confuses the admission of pain with the "sin" of self-pity. Many of their manuscripts, including almost all that were rejected, dealt with a handicap in the most blandly optimistic, honeyed tones and treated total blindness, for example, with the same "grin and bear it" fortitude with which most people speak about a toothache. Although the original purpose of this book was conceived in reaction against just such an attitude, a few such manuscripts have been included simply because they do represent an attitude toward a handicap that may be more widespread than any other.

Many handicapped persons seem to believe self-pity is akin to moral cowardice. But some find it to be a potential contributing factor toward a successful rehabilitation. One can recognize this point in my own account of the personal crisis through which I passed when I realized that I was to be permanently crippled; one can see it in Sandra Noddin's account of her desire to break out of the tight little world of the blind; and one can feel it beneath the hard dignity of Moses Singleton's story. This is not to imply, of course, that self-pity is necessarily desirable. It does, however, suggest that, consciously or unconsciously, self-pity can be turned to advantage.

The handicapped person has also to contend with loneliness—perhaps the greatest of all social and psychological threats in the United States today. Even when loneliness is obvious, many people have difficulty admitting it to themselves, much less to others. And many handicapped people, faced with the prospect of making so basic an admission, choose rather to deny their loneliness. The handicapped person, after all, is a member of his society, and he derives his values, goals, and satisfactions from the same cultural milieu as the nonhandicapped. Some of the contributors—along with a great many others whose manuscripts had to be marked "omit"—refuse to admit that the possession of a severe physical handicap is any reason whatsoever for a person to be lonely. But others speak quite candidly about their isolation. Doris Lorenzen, for instance, does not mention much of the physical pain or loneliness that she has been forced to endure, but she neither avoids nor denies them. Loneliness is there, stamped on every page of her story, but, rather than tell us about it, rather than label it, she permits us to see the long months in a hospital, the long ensuing months in a bed at home. And she permits us to see this truthfully, tracing her experiences with both restraint and incisiveness, conveying both the pain and loneliness through which she passed.



Some of our contributors are obviously bitter about what they have experienced. It is not, after all, easy for a person with a physical handicap to avoid bitterness. When a professional musician loses his sight, when a high school athlete finds himself permanently confined to a wheel chair, when an adolescent girl is unable to apply make-up to her face because she cannot control the spasms in her arms, there is a more than sufficient basis for personal bitterness. And yet the very admission of such bitterness, whether it is based in reality or is used by the handicapped person as a psychological weapon to deny his own personal failure, poses still another problem. Bitterness, like loneliness, is no longer part of the acceptable canon of personal feelings in the United States. Thus, the handicapped person finds himself presented with another social taboo—one that insists that he express his pain, his desires, his hopes, and his anguish only in the most superficial manner; if he expresses his bitterness deeply or with any sense of personal tragedy, he risks alienating the nonhandicapped.

The handicapped person who alienates the nonhandicapped may find himself socially isolated. For, although there are many exceptions, most nonhandicapped persons find themselves confused and embarrassed in a social situation with, for example, a victim of cerebral palsy. The easiest way for them to deal with their own reactions is to drop some ostensibly light-hearted remark about handicaps in general. Thus, the nonhandicapped person, seeking to protect himself, insists on keeping the relationship as superficial as possible. The handicapped person, on the other hand, enters into the relationship with great anxiety, wondering how much of a barrier to any real social intercourse his handicap will be. When he finds that the relationship is expected to be superficial, his anxiety increases. A number of such superficial relationships may even induce him to withdraw as much as possible from the society of nonhandicapped individuals.

Harold Yuker, in speaking about how he views his own handicap, writes:

In my opinion, people are people, and whether they are black or white; Catholic, Jewish, Mohammedan, or Protestant; disabled or nondisabled, is immaterial.

This statement provides an excellent example of the attitude that nonhandicapped people believe they should maintain in their relationships with handicapped people. It is, for one thing, highly democratic, for it implies a basic equality between all men in social relationships. But it also denies, by implication, that the handicapped individual is handicapped.

As long as a handicapped person is cheerful and light-hearted, he is, like the "jolly fat boy," usually accepted by his peers. But let him hint that it is difficult to live without sight, that it is infuriating to want to eat a meal quickly and find that he is physically unable to do so,

that it is impossible to conceal sexual desire simply because his legs will not respond to his will, and he is likely to find that his audience is nervously avoiding his eyes, that a few embarrassed coughs have now taken the place of laughter, and that what is flashing across the television screen has suddenly become a focal point of interest.

The truth is that, in most cases, whether one is "disabled" or "nondisabled" is not only material but is frequently the decisive factor in social relationships between handicapped and nonhandicapped individuals. Many handicapped individuals have been rejected by their peers simply because their handicaps caused these peers extreme discomfort. On the other hand, some handicapped people have found themselves the object of attention because of their handicap and have succeeded in exploiting this in social situations. Bonnie Jane Garrett tells us of her friend who "felt jealous of my handicap because I attracted more attention and more unusual people than she could with her uncomplicated situation." She then goes on to admit that she "dramatized" her condition as a cerebral palsy victim. Few handicapped people are themselves capable of seeing this, much less admitting it. But the fact remains that many of them actively *exploit* their disabilities, although, since the process is usually unconscious, most of them would probably indignantly deny it.

This kind of social exploitation of a handicap is integrally related to the cultural stereotype of pity for the underdog that has become prevalent in the United States. It can often be a useful stereotype in that it underlies many of our efforts to improve the conditions of the poor, the sick, and the socially rejected. But what such a stereotype does to the individual battling the effects of a physical handicap is another matter. The patient with poliomyelitis, the man with arthritis, the woman with cerebral palsy, the child who loses his sight—all are victims of public relations technics that stimulate in the public that cloying sentimentality so well represented in mammoth telethons. One wonders whether any of the people responsible for fund-raising in this country have ever imagined themselves in the place of, say, an adult man with cerebral palsy watching a telethon designed to raise funds for the prevention and cure of cerebral palsy. If he has any sensitivity whatsoever, such a "show" forces him to retreat yet further into himself; it adds to his fund of pain and increases his reservations about coming into contact with nonhandicapped people. It informs him that acceptance in the outside world depends upon his willingness to make of himself a pathetic creature—and to remain one so as to serve as the underdog that so many people find necessary. Such programs are ostensibly designed to help him, but the alleviation of human suffering seems to have been lost in the rather revolting antics of such Hollywood "personalities" as Jerry Lewis.

And so, if the handicapped individual does attempt to take advantage of his handicap, is he to be blamed? Our

## ARTICLE OF THE MONTH

newspapers, magazines, books, motion pictures, and television dramas all beat a constant tattoo of how some individual exploited his "personality" in order to achieve success. If he is able to exploit the fact that he walks on braces and crutches, is not the victim of poliomyelitis acting in accordance with the "image" of him that has been projected by the campaigns of the March of Dimes? His braces and crutches may be considered a part of, or at least an expression of, his "personality," just as the gray flannel suit expressed Madison Avenue's "image" of its own success. We have come so far in projecting images of human beings that it may even be that the victim of a physical handicap should be actively encouraged by occupational therapists to take advantage of his handicap, just as he is taught to compensate for weakness in one part of the body with strength in the other.

The handicapped person is frequently asked to take comfort in such rehabilitation clichés as: "All people are handicapped." Like most clichés, this one has a certain undeniable validity. But is the fact that some people have crooked teeth or childhood scars of any real comfort to, for example, a man whose total blindness has chained him to a transcribing machine? Again, what we are confronting is an attempt to minimize a handicap, an attempt made more in the interest of the nonhandicapped individual than of the handicapped. To assert that handicapped and nonhandicapped face similar psychological problems is to substitute a wasteful kind of sentimentality for constructive thought. Braces on one's teeth simply are not the same as braces on one's legs, and no amount of rationalization will change that fact.

Frequently the handicapped person is forced to pretend that he is not aware of his handicap. A number of the narratives in this book either state this attitude explicitly or imply it. The denial of a handicap as a handicap was even more prevalent in the large number of rejected manuscripts. One potential contributor wrote, "Being blind is not a handicap. My life is exactly like that of other people." This statement stands not, obviously, as truth but as an excellent example of what a culture responsive to Hollywood confuses with courage. Unfortunately, such an attitude is frequently encouraged by the rehabilitation practitioner who, in his desire to help the patient with his physical needs, may overzealously subscribe to this kind of "courage" and use it as an example of what is desirable. But most handicapped people, when learning to combat their handicaps, must face such an attitude with awe and bewilderment; it is a denial of their own suffering and pain, an implication of some sort of moral cowardice on their part.

The patient's lack of awareness of the permanence of his handicap is among the most important problems facing the rehabilitation practitioner. He must attempt to help his patient *adjust* to a physical condition that is usually permanent, but he finds that his patient is not

aware of its permanence. Thus, he may be put in the difficult position of first discouraging his patient in order eventually to encourage him. Such an approach may easily lead both to confusion and to psychological tension on the part of the patient, for he is never quite sure of where he stands.

And yet, the lack of awareness of a handicap is often surreptitiously encouraged even by those professionally responsible to the handicapped: doctors, therapists, rehabilitation practitioners, social workers, all are sometimes guilty of taking the easy way out, of placating a patient's anxieties rather than attempting to guide him to take a realistic view of himself and his situation. Much of this is undoubtedly done with the patient's welfare in mind; but much of it is nonetheless destructive. The situation in which the doctor finds himself is especially difficult. It is his job to be the first to alert the patient to the possibility of permanent handicap; one runs across numerous handicapped people who are especially embittered toward members of the medical profession for what they consider to be negligence. "It was a *whole year*," said a young accountant who had been seriously crippled in an accident, "*a whole year* before I could find out that I was paralyzed for good. During those damned long months in bed, I could have been thinking out a lot of things, thinking them out and then thinking them out better. As it was, I had to make new decisions on a new basis all at once, and at the same time that I had to begin work and a new way of living."

The physician, however, is in a quandary of his own, one that the patient does not usually consider. For one thing, it is not always possible to render a long-term prognosis until a considerable amount of time after the initial injury has elapsed; for another, the physician must choose what he feels is the correct moment to inform a patient that the injury is permanent. What the patient may see as an arbitrary and unfair decision may actually be the result of a great deal of contemplation. Perhaps the young accountant's bitterness was justified, but it is also possible that, had the physician informed him of his condition immediately, he would have fallen victim to something far more intense than bitterness—despair.

Overprotective parents, friends, relatives, and acquaintances, usually acting with the best of intentions, can make the road to adjustment even more difficult to travel than it ordinarily is. They stress the concept of "normalcy"; they insist that the cerebral-palsied child demonstrate that he is "as good as anybody else"; they encourage the victim of poliomyelitis to participate in activities in which he can function only as an embarrassment to his friends and to himself; and they do all of this in the belief that they are helping that individual to "adjust to reality."

What this approach fails to take into account is the culture within which the handicapped person functions.

It is one thing, for example, for a young boy in an orthopedic hospital to play wheel-chair basketball—it is quite another thing for that boy's mother or father to insist that he play basketball in a wheel chair with a group of physically sound friends. In the first case, he is participating in an athletic function that is part of an established norm. In the second, he can function only as an object of pity or embarrassment or even secret ridicule; rules must be changed for his benefit, and his presence imposes a strain upon his friends; he becomes a "grotesque," valued by his peers not for his own talents as an individual but for a certain psychic gratification he gives them—the feeling of having done something "good" in permitting him to play. And this attitude is unconsciously encouraged by a public brought up to savor the vicarious thrills of cheap melodrama. In our tabloids, we are confronted by pictures of a "postpolio" *sitting* on a pitcher's mound to participate in a baseball game; on television, we are greeted by "This Is Your Life" triumphs of saccharine sentimentality; on radio, disk jockeys speak, in tones properly reverent and somber, of how they learned the "true meaning of courage" from listening to a 7-year-old blind girl.

All this leads one to wonder what it is the physically handicapped individual should adjust to. Is he, in his search for a life of his own, to latch onto the hole offered him by society, to make his bed in a flotsam of sensationalism, to play the clown to his own pathos? Or is he, rather, to try to equip himself with certain basic substitutes for what he has lost physically, to be his own man, who demands no other excuse for his existence? It is easy enough to nod one's affirmation to the latter, but the choice itself is not that easy. The former role, although it robs the handicapped individual of dignity, does guarantee him a modicum of satisfaction; he is accepted by others, is part of a group, is granted if not self-respect at least the right to exist. He is not, in short, overly embarrassing to others. This may not be a role to be envied, but *it is* a role. But if he demands the right to be his own man, if he insists on living according to his own definition of what is right or wrong for him, then he must run the risk of alienation. He must face the prospect of going it alone, and he must do so in a country that is not, despite what our magazines tell us, filled with admiration for the independent man.

The belief that many handicapped people have of being employed at less than capacity is, as we have pointed out earlier in the book, another two-pronged problem. On the one hand, the belief is frequently justified; handicapped people, like Negroes and other minorities, are often the victims of a none-too-subtle prejudice. On the other hand, the very existence of such a prejudice enables the handicapped individual, again like the Negro or the member of another minority group, to rationalize personal failure by blaming it upon an out-

side source. But this rationalization, too, seems to be part of our cultural ethos: many nonhandicapped people, if not most, when questioned, would probably claim—and not always with justification—that they, too, are not employed at capacity, that their work is undervalued.

What we have said about employment is equally true of education. Again, the handicapped person, when he verbalizes his desire for an education, is operating in terms of the general cultural ethos. This desire goes hand in hand with the desire to better oneself, and both are indigenous to handicapped and nonhandicapped alike. But the handicapped person does have to face, as we have already shown, a number of difficult and special problems in order to acquire an education, especially a college education. Because colleges and universities are generally conservative, many of them resist the admittance of handicapped persons. This fact may account, at least in part, for the disproportionate academic success of those handicapped students who do manage to go to college.

The decision to compete in school with nonhandicapped students requires unusual personal deliberation and perhaps even professional advice. The handicapped student must recognize that many achievements will take him much longer than the nonhandicapped student; frequently he comes to college with inadequate secondary school preparation; many of the usual areas of college activity are barred to him; he may find that certain courses, such as laboratory sciences, offer insurmountable physical obstacles. But with all this, he usually has a great impetus to succeed in his academic work. For a college education is, at its best, a question of intelligence and sensitivity rather than one of physical prowess. And despite the numerous physical obstacles that it poses for a handicapped individual, the fact is that long-distance runners are not better equipped to solve problems in calculus than are amputees, that Shakespeare can be just as appealing to a victim of cerebral palsy as to a gymnast, and that an individual in a wheel chair can derive as much intellectual satisfaction from reading Spinoza as one who can walk. Most of our contributors who did manage to go to college found the process of learning enjoyable and stimulating, for it granted them greater equality than did most of their nonacademic activities.

As we stated in the Introduction, we did not intend to offer a "definitive" approach to the problems involved in rehabilitation. But it would be foolish to deny that, as a result of the material collected in this book, we have been led to question a number of current rehabilitative practices and beliefs. There appears, just to cite the most obvious example, to be a lack of integration among different aspects of rehabilitation, and it would seem that a strenuous effort to relate physical, psychological, and vocational rehabilitation needs to be made. In

(Continued on page 305)



## Review of the Month

# Orthopaedic Appliances Atlas, Volume 2 Artificial Limbs

by  
American Academy of Orthopaedic Surgeons

Published by J. W. Edwards, Publisher, 2500 S. State St., Ann Arbor, Mich. 1960. 499 p. figs., tabs., charts. \$15.00.

### About the Book . . .

Volume 2 is published under the auspices of the American Academy of Orthopaedic Surgeons in co-operation with the Office of the Surgeon General and the Veterans Administration. The members of the Academy's Committee to Study Braces and Prostheses, as listed in the Preface, are: Rufus H. Alldredge, M.D., Chairman; George T. Aitken, M.D., Vice-Chairman; Charles O. Bechtol, M.D.; Clinton L. Compere, M.D.; Cameron Hall, M.D.; Donald B. Slocum, M.D.; Dana Street, M.D. The contributors to the volume, too many to list here, are identified on a preliminary page.

Volume 1 of the Orthopaedic Appliances Atlas was published in 1952 by J. W. Edwards; it is subtitled Braces, Splints, Shoe Alterations.

### About the Reviewer . . .

Dr. Mazet, after being graduated from Brown University, attended Columbia University, receiving his M.D. degree in 1928. In private practice until he entered the U.S. Navy, serving from 1941 until 1946, he was chief of orthopaedic service at the Veterans Hospital, Los Angeles, from 1946 to 1961. He is presently director of research, Orthopaedic Hospital, Los Angeles. Dr. Mazet is a diplomate of the American Board of Orthopaedic Surgery, a fellow of the American College of Surgeons and of the American Association for the Surgery of Trauma, and a member of the American Academy of Orthopaedic Surgeons, the Western Orthopaedic Association, and the American Orthopaedic Association.

### Reviewed by Robert Mazet, Jr., M.D.

THIS SECOND VOLUME of the *Orthopaedic Appliances Atlas*, covering artificial limbs, had a prolonged gestation, threatened to abort on several occasions, was characterized by agonizing and prolonged labor pains, but finally delivered, a well-formed lusty child.

In scope and arrangement it more or less parallels the pattern set by Volume 1. The book completely encompasses the field of artificial limbs. The various chapters are logically chosen. The bibliographies at the ends of the chapters are voluminous; the illustrations are numerous and helpful; the text is readable and clear throughout most of the volume.

The introductory chapter on the historical background of present-day prosthetics is inspiring and informative for the student. The chapter Upper-Extremity Components not only lists these but offers a description of their functions and motions, with some discussion of their virtues and defects. Prescription for the individual amputee is emphasized. The desirability of simplicity and dependability as opposed to appearance or fine motions in the devices is stressed.

The dissertation on Construction and Fitting of Upper-Extremity Prostheses and that on Harness Patterns for Upper-Extremity Prostheses record, in almost too much detail, the methods of taking stump measurement and impressions, of prosthetic fabrication and alignment, of harness pattern and manufacture. The delineation of the several amputation levels, with emphasis on the necessity to try to replace the loss of function incurred at each level, is well done. The application of components and harness patterns to the loss at various levels is explained. The check out procedure for the completed prosthesis is clearly described and illustrated. The fundamental dual requirements of harnessing are shown: retention of prosthesis on stump and transmission of energy to operate the device.

The chapter on Lower-Extremity Components occupies 133 pages. Its mass of detail, particularly relating to the divers types of knee joints,



with speculation as to possible future improved mechanisms, is completely confusing. Indications of the usefulness of the many components to prescription for the particular amputee are obscure for the most part. It is relieved by three worth-while suggestions: 1) the use of articulated temporary legs with well-fitted sockets in geriatric amputees when ability to handle a prosthesis is in doubt, 2) prescription of elephant boots or stubbies in unstable bilateral amputees to help them regain balance, increase muscle tone, and build self-confidence, and 3) the use of a cane (or canes) by the debilitated patient. The implication that an amputee with a fixed hip flexion contracture can "walk it out," or decrease the deformity by walking in a prosthesis, is not borne out by clinical observation. Allowance for the flexion must be made in fitting and aligning the socket.

Construction and Fitting of Lower-Extremity Prostheses, the following chapter, repeats some of the data in the previous one relative to components and materials. The principles of socket alignment, socket shape, and putting most of the weight on bony areas best suited to this task are nicely expounded. The use of the adjustable leg developed at the University of California, Berkeley, is ably explained. The evolution of some of the presently used types of prostheses is briefly given.

A definition of rehabilitation that should be more widely understood is stated in the chapter on Physical Treatment and Training of Amputees: "Rehabilitation is not a medical specialty, but more a necessary philosophy for treatment of the handicapped" (*p. 313*). There is an excellent dissertation on the necessity for preoperative preparation and postoperative rehabilitation, with an adequate outline of the training programs.

The chapter on Anatomical and Physiological Considerations in the Clinical Application of Upper-Extremity Prostheses contains a good review of the components available for fitting the various levels of amputation, the types of stumps these are used for, with some brief hints on shaping of sockets. This is followed by a chapter on the anatomy and physiology relative to the lower extremity. Posture, balance, and gait in the normal person and in the amputee are compared. The types of amputee gait, the reasons for variations, recognition and correction of gait abnormalities, and the necessity for stability in the above-knee prosthesis are explained. The advantages of a good training program are brought out.

The Principles of Amputation Surgery, the next chapter, is a brief review of the reasons for amputation and technics of open amputation and the standard closed, or flap-type, operations at various levels. The duty of the surgeon to prepare the patient for amputation and to supervise his postoperative care is barely mentioned. The function of the surgeon as captain of the prosthetic team, his responsibility to direct the entire rehabilitation program, and his

relationship to prosthetist and amputee trainer could well be expounded here. The clinic team and its combined responsibilities are discussed in the following chapter on Prescription in the Prosthetics Clinic. Here prescription of those components that will best serve the individual amputee is discussed in relationship to his physical loss and his psychophysiological constitution.

The chapter on Cineplasty is a good review of this subject. It clearly indicates that this operation should be done only for a small group of carefully selected patients after they have demonstrated good use of a conventional prosthesis. It is rarely indicated for children.

The Special Problems of the Juvenile Amputee are considered separately. This is proper, for amputee problems of childhood differ from those of adults in the same way that fracture problems differ. The stage of development of the amputee, his growth potential, and the not infrequent necessity to fit a malformed, partially developed extremity complicate and modify the care of these young people. This chapter is one of the highlights of the book.

If this volume has a serious fault, it is that of over-inclusiveness. Nothing is omitted. Co-operation among the members of the "prosthetic team" to the advantage of the amputee is stressed throughout the opus. This lucky child, fathered by the American Academy of Orthopaedic Surgeons and long in the womb of the Committee to Study Braces and Prostheses, waxed fat in its prenatal environment. It is thrust upon the world well-molded but overweight. Had it been delivered earlier, it might have been smaller but would have been more muscular, and probably more readable.

## Other Books Reviewed

736

**Massage Techniques; A Case Method Approach**

By: Frances M. Tappan, B.S., M.A.

1961. 204 p. figs., chart. Spiral binding. Macmillan Co., 60 Fifth Ave., New York 11, N.Y. \$5.50.

THIS DETAILED SURVEY of the variations in the application of massage, as practiced in the United States and abroad, gives careful descriptions, comparisons, and evaluation of technics. Although based primarily on the methods of Albert J. Hoffa, Mary McMillan, and James B. Mennell, technics from the system of Elizabeth Dicke, widely used in Europe, are also described briefly. Some of the strokes from the Dicke system have been adapted by Miss Tappan to fit systems commonly used in the United States. Since the book was written as a practice guide for

## BOOK REVIEWS

students, the case study method includes samples of many injuries and illnesses where massage would be useful. In reviewing each case the student is expected to relate it to total care of the patient; the legal, practical, and psychological aspects of each should be considered, Miss Tappan points out.

Miss Tappan is associate professor and director of the School of Physical Therapy, University of Connecticut. Her book should fill a long-felt need for a textbook on comprehensive coverage of the major systems of massage; schools of physical therapy, physical education, nursing, and osteopathy may find it useful.

737

### **Mental Retardation; Readings and Resources**

Edited by: **Jerome H. Rothstein**

1961. 628 p. tabs. Holt, Rinehart and Winston, 383 Madison Ave., New York 17, N.Y. \$6.75.

FROM 5,000 ARTICLES AND REPORTS published in the past 25 years, the author has selected 56, all by well-qualified and authoritative persons from the fields of medicine, education, psychology, speech, vocational guidance, and sociology. These, together with the historical background material, the supplementary bibliographies, and information on resources, provide comprehensive coverage of the subject and illustrate the multidisciplinary approach needed in the solution of the wide variety of problems mental retardation presents to both the family and the community. The author has planned the book to serve as a college text in education courses, in association with basic books on mental retardation or in conjunction with curriculum guides for educable and trainable children, and as a source of information for parents and parent groups.

The author has incorporated in this book various bibliographies he issued in 1954 and 1955; all have been brought up to date. The appendix includes a state-by-state chart of clinical services for the mentally retarded, a classified film list, where obtainable, and a listing of journals in mental retardation and related fields.

738

### **Problems in Vocational Counseling; The Application of Research Findings**

By: **Lloyd H. Lofquist and George W. England** (Introduction by Donald G. Patterson)

1961. 186 p. figs., tabs., charts. Wm. C. Brown Co., Publishers, 135 S. Locust St., Dubuque, Iowa. \$3.50.

THE PROBLEM-STUDY APPROACH used by the authors of this book, intended as a supplementary text for courses in vocational and occupational counseling, em-

phasizes important considerations in the counseling process by involving the reader in the actual interpretation of research data. The 46 problems represent comprehensive coverage of the field without being exhaustive, in the opinion of Dr. Patterson, Professor of Psychology and staff member of the University of Minnesota Industrial Relations Center, given in his Introduction to the book. The presentation of each problem is followed by a discussion containing what might be considered a "school solution"; in many cases alternate interpretations and additional implications are possible. Source for the data is indicated, with additional pertinent references, at the conclusion of each problem. The 7 parts of the book cover: the nature of vocational counseling, meeting individual needs in counseling, the use of tests, the counseling interview, work history data, occupational information, and facilitating the counseling plan.

For convenience, all references given are listed alphabetically at the end of the book; an additional aid is the Text Reference Chart prepared for instructor and student use, to integrate the problem approach in teaching vocational counseling with some of the major texts in the field.

739

### **Proceedings of the Workshop: Practice of Social Work in Rehabilitation**, Co-sponsored by The School of Social Service Administration, University of Chicago, and The National Society for Crippled Children and Adults

Edited by: **Mary W. Green**

1961. 159 p. Paperbound. Available from National Society for Crippled Children and Adults, 2023 W. Ogden Ave., Chicago 12, Ill. 50¢.

UNDER A GRANT from the Office of Vocational Rehabilitation, the University of Chicago's School of Social Service Administration and the National Society for Crippled Children and Adults planned an educational workshop, combining lectures and group discussion on the appropriate function of social work within a rehabilitation facility. Forty traineeships were made available, with preference going to workers isolated or working alone.

Contents: Rehabilitation in the latter half of the Twentieth Century; recent advances and goals, Eugene J. Taylor.—Challenges to social work: In the vocationally oriented rehabilitation program, Herman Gendel (digested in this issue of *Rehab. Lit.*; see #742); In the community oriented planning and health education program, Mary Thompson; In the rehabilitation center, Faye Katzen.—The social casework method in rehabilitation—constant tool, Bernece K. Simon.—Principles of administration in developing criteria for determination of appropriate functions of social workers in rehabilitation, Edward E. Schwartz.—Selected concepts of small group theory: Their application to groups in rehabilitation settings and to com-

munity organization aspects of rehabilitation service (an edited transcript of two lectures), Mary Louise Somers.—Community planning for rehabilitation, John H. Ballard.—Community organization in process: A panel presentation of two case histories; Introduction, Oscar Kurren; Community organization for special education in St. Louis County, Missouri, John Kniest; Agency reorganization as an expression of community need, Runo Arne.—The adaptive processes of the ego in rehabilitation, Jay Bisgyer.—Work evaluation and work adjustment as a means of adaptation to loss: A panel discussion, William Gellman, Simon Friedman, and Edythe Perlman.—Some adaptations of basic concepts and principles for casework practice in a rehabilitation setting, Florence Haselkorn.—Roles and responsibilities of social work: A key to practice in rehabilitation, Alice James.—Summary of group discussions: I. Major concerns of participants.—II. Ways to approach definition of social work role.—III. Consideration of team practice.—IV. Other content presented: Administration, community organization, group work, work.

740

**Voluntary Health and Welfare Agencies in the United States; An Exploratory Study by an Ad Hoc Citizens Committee**

Directed by: **Robert H. Hamlin, M.D., M.P.H., LL.B.**  
1961. 88 p. figs., tabs. Paperbound. The School-

masters' Press, 82 Morningside Dr., New York 27, N.Y. \$1.00.

**THE HAMLIN REPORT**, based on a study by an *ad hoc* committee established in 1958 at the invitation of the Rockefeller Foundation, attempts to reassess the function and responsibilities of voluntary health and welfare agencies and to evaluate their use of public funds. The Committee sought to find answers to questions regarding voluntary agencies' responsiveness to actual community needs, the desirability of the wide variety of separate agencies, government's role in health and welfare programs and its effect on agency activities, the possible need for supervision of agencies, their use of funds, and how givers can appraise specific appeals.

The report contains much that is already familiar to national voluntary health agencies, long aware of the critical issues involved. A committee of the National Health Council, made up of agency representatives, has been at work on the problem of establishing a uniform accounting and reporting procedure. Though basically appreciative of the work of voluntary agencies, the report expresses critical opinions and offers major recommendations (Chapters 3, 4, and 5) for further study and action by agencies. If for no reason other than honest self-appraisal, agencies should give the book thoughtful study.

The appendix contains an analysis, with statistical data, of trends in American philanthropic contributions and in government expenditures for purposes of health and welfare.

(Continued from page 301)

many of the cases included here, no such effort was made; in others, any mode of rehabilitation was haphazard and hit or miss.

So many other problems have been raised that it would be impossible to go into them here. But the basic and most difficult problem deserves mention. The split between what the handicapped person wants for himself—a life in which he functions as a responsible and equal member of society—and what our national culture is

prepared to give him—a charitable but decidedly second-class right to exist—appears to be growing. Exactly what the solution to this problem is, we do not pretend to know, but it is time that more thought was given to it. And it is not only the handicapped person who must think about it, but rehabilitation practitioners, educators, physicians, psychologists, employers, fund-raisers, and, above all, the much-heralded man in the street. The good society, after all, is that society that can afford to grant all its members the right to be human with dignity.

### The November Issue

The Article of the Month for November will be "Rehabilitation Aspects of Parkinson's Disease," by Robert S. Schwab, M.D., and Albert C. England, Jr., M.D. Dr. Schwab is director of the Brain Wave Laboratory, Massachusetts General Hospital; Dr. England is associated with Dr. Schwab at the Laboratory and affiliated with Harvard Medical School.



## Digests of the Month

*Journal articles, chapters of books, research reports, and other current publications have been selected for digest in this section because of their significance and possible interest to readers in the various professional disciplines. Authors' and publishers' addresses are given when available for the convenience of the reader should he desire to obtain the complete article or publication. The editor will be most receptive to suggestions as to new publications warranting this special attention in Digests of the Month.*

741

### The Therapy of Purposeful Work; a Pilot Study at Wood VA

By: James C. Spaulding

In: *Geriatrics*. May, 1961. 16:230-236.

**A** WORK EXPERIMENT is being conducted at the Veterans Administration Center, Wood, Wisconsin. The key to the project is voluntary purposeful work—employment for 2 hours or more a day at useful tasks, not just busy work. Three years' experience shows an improvement in social adjustment on the part of the residents; personal hygiene and appearance have become better and leisure-time usage more constructive. The medical department has observed less hospitalization and improved physical well-being of the residents.

Most of the 1,500 residents of the Wood Domiciliary Unit are World War I veterans, about 85 percent with no direct family ties, with an average age of 63 years. Before the pilot program began, discipline in the unit was authoritative, exercised by the manager's court. Little attention was given to the needs of the men beyond food, lodging, and simple wants. Those fit for general duty helped in maintenance, the rest, some 350, in effect sat in rocking chairs and ate apples. Under the new program the number unable to do more than self-care has been reduced to an average of 25 to 30 daily. The success of the program derives from several concepts:

Men are better off doing for themselves what they are able to do.

Activities should be planned with the individual, not just for him.

The cardinal principal is: tasks that contribute to the sheltered community, or outside community, will promote self-esteem and contentment.

The pilot project has focused upon the 350 severely disabled residents, the many in wheel chairs. As in the case of most of the residents, many of the men come from mechanical or laboring backgrounds, but Richard N. Filer, Ph.D., the psychologist in charge of the program, learned to his surprise that they were more interested in clerical work. The answer to this paradox may be that their strength and speed, required in their previous work, were qualities they had lost. As a result the clerical workshop is the important element in the voluntary work program.

Assessment of the new resident is the first part of the program. Within the first day after arrival, he is given a complete physical examination in the domiciliary clinic. For the psychological evaluation the pilot program staff makes use of group tests and interviews. The physician next checks the medical findings and explains them to the new resident, relating them to the living activities at the unit. For the severely disabled resident the special planning board arranges his program of work, recreation, and other activities. The less handicapped residents appear before the general planning board.

To make the workshop activities purposeful, Dr. Filer insists that the organizations or other departments offering work pay for the materials. In the clerical workshop, tasks performed include assembling clinical folders for the hospital, stamping forms for routing patients, and making meal tickets. In other workshops bandages are made, furniture mended and refinished, and electrical equipment repaired. Special devices and aids are utilized, and jobs are broken down into components. A man with one useful hand may not be able to refinish an entire piece of furniture but can sand a part that is held in a clamp. A man who cannot alphabetize can at least separate the A's from a group of cards. Ingenious devices have been worked out enabling a one-armed man to staple booklets or a man with severe tremors to stamp forms in the right place. In the greeting card shop patients with talent will design cards and less talented will fill in the stenciled designs.

When an older person says he can't work, he often means he has tried and failed. If given a chance, he will often go to some lengths to overcome an obstacle. For example, a physician at Wood saw a man with Parkinson's disease, on his way to Sunday chapel, unable to step over a ridge of ice. Before the doctor could come to his aid, the man sat down on the sidewalk, slid over the ridge sitting down, and shuffled on his way.

Dr. Filer plans to offer additional incentives to the part-time work, other than knowing the work is useful and obtaining self-esteem. Three types of rewards will be offered to find out what motivates a man with limited ties to the outside community:

Coupons for the resident to buy cigarets, candy, and other items for himself.

A form of credit that may be applied to buying something for the group, such as equipment for the recreation club.



A chance to help someone in the outside world—work credit, for example, may be used to help feed, clothe, and educate a child in a foreign country.

The pilot program may help to answer the intriguing question whether elderly residents at Wood will work only to fill their own personal pleasure needs, or elect to work for less selfish ends.

*Geriatrics is published monthly by Lancet Publications, Inc., 84 S. 10th St., Minneapolis 3, Minn.; annual subscription rate: \$8.00, single copy, \$1.00.*

742

### Challenges to Social Work: In the Vocationally Oriented Rehabilitation Program

By: Herman Gendel (*Case Consultant, Jewish Vocational Service, 1 S. Franklin St., Chicago 6, Ill.*)

In: *Proceedings of the Workshop: Practice of Social Work in Rehabilitation*, cosponsored by The School of Social Service Administration, University of Chicago, and The National Society for Crippled Children and Adults, Inc., p. 19-22. 1961. 159 p. Paperbound. National Society for Crippled Children and Adults, 2023 W. Ogden Ave., Chicago 12, Ill. 50¢. (See #739, this issue of *Rehab. Lit.*)

THE AGENCY in which I work places and counsels unemployed persons—unemployed because of vicissitudes of the labor market, lack of work experience, a long absence from the labor market, failure to ever adjust to work and its requirements, physical, emotional, or intellectual handicaps, or a multitude of other reasons. Vocational placement is our program goal. Processes used to achieve this are varied.

A person who comes to us assumes, first, that he will be dealt with as an individual, second, that our agency has the means and resources to help him vocationally. The agency assumes the person has a vocational problem and is willing to do something about it. Our job is to see if our resources can solve his problem, using an individual relationship—the process of engagement or relationship is the casework method, the basic technic the interview, first making a diagnosis and then treating, as in other helping relationships.

The diagnosis may be simple. For a stenographer whose firm has moved out of town, the diagnosis may be job replacement, the treatment aid in getting a job demanding experience similar to that of her old job, with the same pay and approximate location.

The diagnosis may be difficult—the client, a 20-year-old man, who left school in seventh grade and stayed home because of retardation, convulsions, and fear of going out. For diagnosis, we may wish to interview the man, his parents, get medical reports, perhaps a psychiatric report,

have further medical examinations, do psychological testing, and place him in a diagnostic workshop. Then only will we be able to tell the diagnosis and prognosis. If we feel he is employable, treatment may involve medical and psychiatric help, counseling, and an adjustment work center. In treatment we use counseling interviews, information from auxiliary professions, and reality-oriented workshop experience. Thus, the interview, the basic tool of the caseworker, is expanded, and, while the relationship is central, it becomes one technic among others.

Vocational orientation makes us an extremely reality-based agency. We also have a basic philosophy of vocational service that is dynamic, viewing the client as a totality, understanding his needs and attitudes as important in planning. Work or vocational adjustment problems can be handled separately from other areas of the client's life, but they affect and are affected by the other areas.

Social work is challenged by: the need to re-examine the social worker's general role in vocational rehabilitation; the need to understand and assimilate more fully social and economic factors operating in our society; and the need to understand better the role work assumes in our society.

Although vocational rehabilitation and adjustment have appeared to be devoid of problems traditionally associated with casework, medical social workers and many psychologists find this area offers as much, if not more, opportunity for casework skills as does family, psychiatric, children's, medical, or community work. Relationship, utilization of community resources, interpretation, and case finding involve the same skills. Caseworkers are coming to be used, for they are skilled in aiding persons develop latent capacities for emotional, social, and economic adjustment. Our counselors help clients view their disabilities in relation to self, to family, and to social institutions representing work and society. We help them utilize what they have to function as fully as possible.

Perhaps out of fear of working with objective reality rather than egos and interpersonal relationships, social workers are not enough concerned with, or interested in, the industrial world in which our egos live. Society asks us to fit into an industrial world created by technology. In addition to a knowledge of personality dynamics, understanding of economic social factors should be a prime tool. The institutionalization of work, status roles derived from the work role, the way we view and are viewed by people are growing central to our life role.

As caseworkers we have been only occasionally involved with the role work plays in a person's life—work relationships seldom become the central focus of our relationship and treatment. In a vocational rehabilitation

(Continued on page 323)

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## Abstracts of Current Literature

This abstracting section, together with other numbered references indexed in this issue, serves as a supplement to the reference book *Rehabilitation Literature 1950-1955*, compiled by Graham and Mullen and published in 1956 by the Blakiston Division of McGraw-Hill Book Company, New York. An author index will be found on the last page of the issue.

### AMPUTATION

743. Aitken, George T. (920 Cherry St. S. E., Grand Rapids 6, Mich.)

Management of the child amputee, by George T. Aitken and Charles H. Frantz. (50) p. illus. In: *Am. Acad. of Orthopaedic Surgeons Instructional Course Lectures*. Ann Arbor, Mich., J. W. Edwards, 1960. Vol. XVII, p. 246-295.

The recommended program for management of juvenile amputees, reviewed comprehensively here, is based on experience with 564 child amputees over a 13-year period at the Area Child Amputee Center, Grand Rapids. Differences between adult and child amputees in the fitting of prostheses are outlined; physical differences are modifying factors in the surgery of amputation in children. Prosthetic devices for children, age of fitting of both lower and upper extremity prostheses, and the group approach to training of juvenile amputees are discussed fully, with illustrations, charts, and graphs. Following discharge from the training program, regular follow-up outpatient clinic visits are scheduled. It is emphasized that child amputees have greater habilitation potential than do many children with poliomyelitis or cerebral palsy. Bibliography.

### AMPUTATION—EQUIPMENT

See p. 302.

### APHASIA

744. Myklebust, Helmer R. (School of Speech, Northwestern Univ., Evanston, Ill.)

Aphasia in children; suggestions for management and training. *J. South African Logopedic Soc.* June, 1961. 8:1:6-13.

Dr. Myklebust offers parents and classroom teachers background information on normal development of language in the child, defines aphasia and its causes, and discusses behavior characteristics of the child with expressive or receptive aphasia, his problems, and his needs. Specific suggestions on home training to develop language and on the management of everyday activities such as eating, personal hygiene, and play are included. A brief explanation of an appropriate approach to language training is given, for the benefit of teacher and therapist.

See also 785; 786.

### ARTHRITIS—MEDICAL TREATMENT

745. Gowans, James D. C. (25 Bennet St., Boston 11, Mass.)

The management of rheumatoid arthritis. *GP.* Aug., 1961. 24:2:107-116.

A review of treatment technics, the prevention of deformity, use of drugs, need for hospitalization, and general guidance of the patient. Physicians must understand that individualized long-term programs are required and that drug therapy alone is never sufficient. In the initial evaluation, the patient's emotional make-up, nutritional status, social and economic background, occupation, habits, and responsibilities must be recorded.

### AUDIOMETRIC TESTS

746. Fry, D. B. (University College, London, W.C.1, Eng.)

Word and sentence tests for use in speech audiometry. *Lancet.* July 22, 1961. 7195:197-199.

The author and the late Dr. Phyllis Kerridge published in 1939 the first articulation tests specifically designed for deaf persons; this article offers revised sentence material (10 lists with 25 sentences each) and new word-articulations tests containing only monosyllabic words (10 lists of 35 words each). New material should be welcome since it is not advisable to use a test list twice with the same patient, no matter how long the interval between testings. The rationale of, and need for, speech audiometry are discussed briefly and instructions for administering and scoring results of tests are given. Word lists are included but lack of space necessitated elimination of sentence lists. Copies of sentence lists or tape recordings of both sentence and word lists are available (at cost) from the Department of Phonetics, University College, London, W.C.1, England.

See also 800.

### BACKACHE

See 801.

### BLIND—SPECIAL EDUCATION

747. New York. State Education Department. Bureau for Handicapped Children

*Adapting materials for educating blind children with sighted children.* Albany, The Bureau, 1961. 40 p. illus.

Adapted equipment for use with blind children attending regular public schools is pictured and described; the instructional aids are intended for kindergarten and elementary grades, to promote academic skills and provide opportunity for small group activities. This is the second in a series of publications planned for teachers and administrators of programs for blind children (see *Rehab. Lit.*, May, 1960, #326).

Available from New York State Education Department,



## ABSTRACTS

Bureau for Handicapped Children, Albany 1, N.Y., at \$1.00 a copy.

### BRAIN INJURIES—DIAGNOSIS

748. Daryn, E. (52 La Guardia St., Tel Aviv, Isr.)

Problem of children with "diffuse brain damage"; clinical observations on a developmental disturbance. *Arch. Gen. Psychiatry*. Mar., 1961. 4:299-306.

A report of a survey of 170 children referred for psychiatric consultation at the Mental Health Clinic, Tel Aviv, Israel; children were examined for the purpose of clinical treatment rather than for research purposes. Of the group, 84 were found to have "diffuse brain damage," diagnosis being based on their clinical behavior (hyperkinesia, impulsivity, short attention span, perseveration), minor neurological findings, and slight signs of malformation. The author believes that, in many cases, the condition represents a growth disorder (maturational lag), subject to possible future improvement, rather than a final, static condition of the brain. Diagnostic problems and the possible value of treatment methods are discussed.

See also 785; 786; 805.

### BRAIN INJURIES—PSYCHOLOGICAL TESTS

749. Cruse, Daniel B. (Univ. of Arkansas, Fayetteville, Ark.)

Effects of distraction upon the performance of brain-injured and familial retarded children. *Am. J. Mental Deficiency*. July, 1961. 66:1:86-92.

According to Strauss and his coworkers, brain-injured retarded children, characterized as abnormally responsive to environmental stimuli, hypervigilant, and mobile in attention span, should be taught in classrooms with a minimum of auditory and visual stimulation. In the present study, brain-injured children, in general, were not shown to be more distractible than the familial retarded when tested on a visual reaction time task under varying conditions of distractibility, except in the case of brain-injured children showing definite signs of organic injury. Both familial and brain-injured retarded children were found to benefit from minimization of environmental distraction.

750. Rowley, Vinton N. (Dept. of Psychiatry, State Univ. of Iowa, Iowa City, Iowa)

Visual retention test performance in emotionally disturbed and brain-damaged children, by Vinton N. Rowley and Paul E. Baer. *Am. J. Orthopsychiatry*. July, 1961. 31:3:579-583.

Performances of emotionally disturbed children on the Benton Visual Retention Test were compared with those of a matched group of brain-damaged children and with the normative standards reported by Benton. The essential findings indicated no tendency for emotionally disturbed children to perform on a defective level on the test; the observed incidence of defective performance was no higher than that found in normal children. There is a tendency for the emotionally disturbed to perform somewhat below expectations for their chronological and mental age, however. The test is believed to have considerable usefulness as an aid in discriminating between brain damage and psychogenic emotional disturbance in children.

### CEREBRAL PALSY

751. Argy, William P. (2800 13th St., N.W., Washington 9, D.C.)

Cerebral palsy. *Georgetown Med. Bul.* May, 1961. 14:4:276-281.

A review of the known facts concerning cerebral palsy and the problems it presents in care and treatment. Authoritative sources are cited. Incidence, etiological classification, clinical signs and symptoms, incidence of associated defects, and the approach to treatment are discussed briefly. Minimum requirements for a professional staff to treat 100 children are listed. This paper was presented as a lecture to the professional staff of the District of Columbia Society for Crippled Children.

752. Pendleton, Thelma B. (6206 S. Champlain Ave., Chicago, Ill.)

Trainable cerebral palsied children. *Phys. Therapy Rev.* Aug., 1961. 41:8:582-585.

Methods described were used in a private day training center with an enrollment of 24 severely involved trainable children (South Side Training Center for Cerebral Palsied Children, Chicago). The 4 basic goals of toilet training, self-feeding, ambulation, and socialization are subdivided into simple activities, assigned carefully in keeping with the therapeutic prescription; written orders for physical therapy are given by competent medical specialists. Adapted equipment, routine safety measures, and emergency nursing care are discussed.

See also 808; 818.

### CEREBRAL PALSY—MEDICAL TREATMENT

753. Goldstein, Hyman (317 E. 17th St., New York 3, N.Y.)

Carisoprodol in the treatment of children with motor difficulties due to brain impairment. *Arch. Pediatrics*. May, 1961. 78:194-199.

A study of the results of twice daily administration of carisoprodol in 72 children with cerebral palsy is reported. Because of its muscle-relaxant properties and contribution to improvement in motor function, Dr. Goldstein finds the drug a valuable adjunct in treatment. Children in the treated group appeared to gain in poise and to be happier and more relaxed, with an increase in attention span and greater receptivity to school instruction.

### CEREBRAL PALSY—PARENT EDUCATION

754. British Council for the Welfare of Spastics

*Outside the treatment room; notes on the physical care of children with cerebral palsy*, by Valentine Culloty. London, The Council, 1961. 12 p. illus.

General guidance in the physical care and handling of cerebral palsied children in the home is offered for parents or staff of residential homes or schools. Proper posture at all times is necessary if the child is to benefit from formal treatment; "carry-over" effects of treatment are lost if parents do not encourage the development of movements as near normal as possible. Discussed are proper positioning while sitting in a chair or on the floor, during feeding, while putting on shoes, toileting, or bathing. Equipment is illustrated; address of each supplier of commercial equipment is given.



Available from British Council for the Welfare of Spastics, 13 Suffolk St., Haymarket, London, S.W.1, England at 2s (36¢) a copy.

**755. Canadian Council for Crippled Children and Adults. Cerebral Palsy Section**

*The parent of the cerebral palsied and the community; the relationship of parents and parent councils to cerebral palsy clinics, treatment centres and other community services*; edited by Keith S. Armstrong. Toronto, The Council, 1961. 34 p. tabs.

The Canadian Council's Cerebral Palsy Section has, for the past 3 years, collected pertinent data from parent groups, professional personnel, and medical advisory committee members. The only practical solution to providing services for the cerebral palsied lies in the integration of the specific services needed by them with the broader services needed by all handicapped children. The implications for parent organizations, government and voluntary agencies, and community facilities are discussed. The functions of parent organizations in the future are considered in broad context; the discussions provide a basis for assessing effectiveness of local or provincial programs.

Available from Canadian Council for Crippled Children and Adults, Suite 115, 31 Alexander St., Toronto, Ont., Canada, at 50¢ a copy.

**CEREBRAL PALSY—SPEECH CORRECTION**

**756. Shapiro, Glenda** (*Forest Town School for Cerebral Palsied Children, Johannesburg, S. Africa*)

Speech therapy for the cerebral palsied child; a plan of treatment based on the Bobath technique, by Glenda Shapiro and Ruth Jacobs. *J. South African Logopedic Soc.* June, 1961. 8:1:4-5.

A speech therapy program using an approach to treatment devised by Berta Bobath is outlined briefly. Before attempting to teach the child speech, the therapist must try to normalize muscle tone of the whole body in the reflex-inhibiting posture described by Mrs. Bobath. Training through the visual sensory field is used more as an aid than as a basic technique; training should be done preferably through proprioceptive pathways. It is essential that the child first achieve head and neck control. The authors point out that this method is only one of many used concurrently in treatment of the speech-defective cerebral palsied.

**757. Shere, Marie Orr**

*Speech and language training for the cerebral palsied child at home.* Danville, Ill., Interstate Printers & Publ., 1961. 40 p. (*Interstate special education ser.*)

In this booklet addressed directly to parents, Dr. Shere, assistant professor of speech, University of Illinois, offers practical advice on training the cerebral palsied child in speech and language, in everyday activities, and in habit formation. The many lesson plans, games, stories, music, and toys described as training aids have all been used successfully. Ways of encouraging relaxation, for improving motivation, and of teaching the child with delayed speech due to hearing loss, and sound advice to parents on the child who cannot learn are discussed. Appendixes contain additional training materials—exercises, activities, and stories—and general rules to be observed in speech and hearing therapy. Two articles by the author are re-

produced from the Feb., 1949, and Feb., 1952, issues of *The Crippled Child*.

Available from Interstate Printers and Publishers, 19-27 N. Jackson St., Danville, Ill., at \$1.00 a copy. (Educational discounts: 10%, one copy; 20%, 2 or more; special discounts on large-quantity purchases.)

**CHIROPODY**

**758. Smiler, Irving** (*1546 Pratt St., Philadelphia, Pa.*)

The medical aspect of foot and leg problems in geriatrics, by Irving Smiler and Robert L. Horwitz. *J. Am. Podiatry Assn.* Aug., 1961. 51:8:559-563.

A survey conducted in 4 homes for the aged revealed that almost all the 100 patients, 65 to 95 years of age, had more than one ailment of the lower extremities. Of those surveyed, 75% were ambulatory. Medical aspects of foot and leg problems in geriatric patients are discussed; many of the conditions can be helped to some degree with accepted orthopedic measures and various physical therapy modalities. The role of the foot specialist on the treatment team is defined. An outline useful in the differential diagnosis of primary arthritic disorders is included.

**CLEFT PALATE—U.S.S.R.**

**759. Lewin, Michael L.** (*707 Broadway, Paterson, N.J.*)

The management of cleft lip and palate cases in the Soviet Union. *Cleft Palate Bul.* July, 1961. 11:3:55-60.

The author's month-long stay in Russia provided little opportunity for examination of patients on follow-up, but children at various institutions showed good postoperative results. Children seen on wards were considerably older than similar patients in the U.S. Complete cleft palates, in Soviet opinion, require orthodontic treatment throughout the whole period of secondary dentition and surgical repair should be done at the end of this period, around the age of 12. The role of the orthodontist and the use of orthodontic appliances are explained. Surgical technics used by Soviet surgeons are described.

The author reviews several articles and the doctoral dissertation of M. D. Dudov (1960). This article is an abstract of a paper presented at the 1961 annual meeting of the American Association for Cleft Palate Rehabilitation.

**CLEFT PALATE—SPEECH CORRECTION**

**760. Subtelny, Joanne D.** (*Orthodontic Dept., Eastman Dental Dispensary, Rochester, N.Y.*)

Palatal function and cleft palate speech, by Joanne D. Subtelny, Herbert Koepp-Baker, and J. Daniel Subtelny. *J. Speech and Hear. Disorders.* Aug., 1961. 26:3:213-224.

Speech and radiographic records of 70 adult cleft palate speakers were studied to determine the relationship between velopharyngeal dimensions and speech proficiency; speech quality was rated by degree of nasality with intelligibility analyzed according to phonetic classifications. Inter-relationships among hypernasality, loss of intelligibility, and large velopharyngeal dimensions were found to show greater variability than reported by other investigators. Although 32% of non-nasal cleft palate speakers did not have complete closure, it was definitely the ex-

## ABSTRACTS

ception rather than the rule for a non-nasal speaker to have a large velopharyngeal dimension. It cannot be assumed, however, that velopharyngeal deficiency is the only factor influencing intelligibility in cleft palate speech production.

## CYSTIC FIBROSIS

761. Stanley, Mildred (436 Capitol Ave., Hartford 15, Conn.)

Connecticut's cystic fibrosis program; first five years, by Mildred Stanley and Victoria Shannon. *Conn. Health Bul.* Aug., 1961. 75:8:259-267.

Preventive aspects of the State Department of Health's program are the detection of genetic carriers and early diagnosis of the disease; all children up to 21 years of age, referred by their own physicians, are eligible for diagnostic service. Eligibility for treatment depends upon establishment of the diagnosis and on the social and economic situation of the family. Responsibilities of the referring physician, role of the Crippled Children Section's staff, financing of care, and services provided by the Connecticut Cystic Fibrosis Association are discussed.

## DEAF—PSYCHOLOGICAL TESTS

762. Lowell, Edgar L. (806 W. Adams St., Los Angeles 7, Calif.)

Experimental Concept Formation Test for preschool deaf, by Edgar L. Lowell and Newton S. Metfessel. *J. Speech and Hear. Disorders.* Aug., 1961. 26:3:225-229.

Describes a test devised at John Tracy Clinic, Los Angeles, to provide normative standards for assessing the developmental process by which preschool deaf children form concepts. The construct validity of the test was determined by correlations, at each age level, between tested abilities on the ECFT and rank order ratings by the teaching staff on comparative abilities in abstracting and making generalizations. The test appears to offer one solution to the problem of determining to what extent deaf children understand concepts they are unable to verbalize or otherwise express.

## DENTAL SERVICE

763. Carney, E. Thomas (Bennie-Dillon Bldg., Nashville, Tenn.)

Dental service in a poliomyelitis respiratory and rehabilitation center, by E. Thomas Carney and Robert E. Merrill. *J. Am. Dental Assn.* June, 1961. 62:683-686.

Dental service instituted at Vanderbilt University Respiratory and Rehabilitation Center in 1957 has provided roentgenograms, prophylaxis, restorations, endodontic treatment, extractions, and oral hygiene education. Every patient admitted to the Respiratory Center who remained 7 days or longer was examined, but not all patients received complete dental care. An unforeseen contribution to total care of patients has been the construction of individual acrylic mouthpieces with suitable attachments. Attention is also given to diet in the hope of preventing caries.

## DRIVERS

764. Marsh, Burton W. (Am. Automobile Assn., 1712 G St., N.W., Washington 6, D.C.)

Aging and driving. *Traffic Engineering.* Nov., 1960. (21 p.)

Various activities to promote safe driving among older persons, including preparation of a self-help guide for aging drivers, a senior citizen traffic study and program, research studies on traffic accident rates in older persons, on night vision, and on criteria of driver competence, are recommended by the director of traffic engineering and safety of the American Automobile Association. Public policy should be based on helping older persons continue to drive enjoyably and safely; however, policy also demands the cessation of driving when competence is impaired.

## DRUG THERAPY

765. Kirman, Brian H. (Fountain Hosp., London, S.W. 17, Eng.)

Tranquilizers for hyperactive children. *Cerebral Palsy Bul.* Aug., 1961. 3:4:379-382.

A psychiatrist suggests that it is better to use drugs rather than physical restraints in dealing with hyperactive children but emphasizes that both should be used only as a last resort. Modification of environment and the routine of management should be given a careful trial before the need for drug therapy is assumed. Drugs can be used in a crisis or during initiation of a change in the organization of a child's life. The value of various tranquilizers is discussed; dosage and choice of preparation vary for different children. Use of drugs should be continued indefinitely until it has been established whether improvement can be maintained without the drug.

See also 753.

## FACIAL PARALYSIS

766. Matthews, W. B.

Prognosis in Bell's palsy. *Brit. Med. J.* July 22, 1961. 5246:215-217.

Results of a clinical study of 156 cases of Bell's palsy underline the need for a more scientific approach to treatment; prognosis for complete recovery of persons seen within 6 days of the onset of Bell's palsy was found to be no higher than 65%. Findings confirmed earlier reports of the relatively bad prognostic significance of advancing years, a complete palsy, and herpes zoster. There is suggestive evidence that recurrent palsy may also be unfavorable. The only absolutely bad prognostic sign was found to be failure of return of any movement after 4 weeks. Main purpose of the investigation was to establish prognosis in early cases.

## HANDICAPPED—BIOGRAPHY

See p. 294.

## HARD OF HEARING

767. Frankel, George W. (6010 Wilshire Blvd., Los Angeles, Calif.)

A planned home auditory training program. *Eye, Ear, Nose and Throat Month.* Aug., 1961. 40:8:560-562.

The program described consists of 3 long-playing records, available from Oto-Sound Laboratories (P.O. Box 49784, Los Angeles 48, Calif.), incorporating 12

lessons of 10 minutes' duration each. Forty speech sounds (vowels, consonants, and diphthongs) are presented in the order of their difficulty in the form of words, sentences, and "words that sound alike." Necessary directions for planned practice periods are included with each set of records. Lessons may be practiced with or without the hearing aid, depending upon degree of hearing loss. The program fills a need of those who are unable to or cannot receive daily training at a hearing center. The editors have no firsthand knowledge of the method and would welcome readers' comments on experience with it.

# HEMIPLEGIA—DIAGNOSIS

768. Ullman, Montague (46 E. 73rd St., New York 21, N.Y.)

Behavioral changes in patients with strokes, by Montague Ullman and Arno Gruen. *Am. J. Psychiatry.* May, 1961. 117:11:1004-1009.

Observations of reactions of 84 patients admitted to a general hospital during the acute phase of a cerebrovascular accident and who experienced hemiparesis or hemiplegia are discussed in regard to the nature and origin of behavioral disturbances due to brain damage. Patients were classified according to the degree of psychological deficit (mild, moderate, or severe). Those who experienced mild strokes with little or no residual mental impairment reacted to stress in their own idiosyncratic manner. In those with moderate or severe strokes the situation was quite different since the organ governing adaptation to stress was itself impaired. Much of what is judged denial in the brain-damaged is such only when interpreted by standards of normal waking behavior.

See also 791.

# HEMIPLEGIA—PHYSICAL THERAPY

769. Zankel, Harry T. (VA Hosp., Durham, N.C.)

Stimulation assistive exercise in hemiplegia. *Geriatrics.* Sept., 1960. 15:616-622.

A report of treatment of the hemiplegic upper extremity by a technic of neuromuscular re-education. Repetitive sinusoidal stimulation of paralyzed muscles, assisted by the patient's own efforts, produced satisfactory or excellent results in 20 of 27 patients so treated. Most of those in whom results were rated unsatisfactory showed improvement in one or more tested movements. Least responsive patients were those with flaccid paralysis or with a spastic paralysis associated with severe contractures. Patients with left hemiplegia responded better than those with right hemiplegia. The technic can be easily adapted to home treatment and administered by intelligent nonprofessional personnel under psychiatric supervision.

# HOME ECONOMICS

770. Stewart, J. B. (Oxford Regional Hospital Board, Oxford, Eng.)

Rehabilitation of the disabled housewife; an experiment in residential training. *Lancet.* July 29, 1961. 7196: 252-253.

Describes facilities and administration of a residential flat attached to the physical and occupational therapy

department, St. Margaret's Hospital, Swindon, Wilts., England. The resident warden, confined to a wheel chair herself, teaches housekeeping methods adapted to trainees' abilities. Patients live at the flat during training, lasting from a few days up to 3 weeks. During 5 years' operation of the unit, 73 residents and many visitors have received instructions on ways to manage homemaking duties. Several case histories are included.

771. White, Joan S. (Orange County Gen. Hosp., 101 Placentia Ave., Orange, Calif.)

Patients cook their way back to health. *Mod. Hosp.* Aug., 1961. 97:2:112, 114, 117.

Weekly cooking sessions for long-term patients, those adjusting to recent disabilities, and patients scheduled for intensive physical therapy have proved to be a morale booster, a socializing influence, and an added incentive to work harder at exercising damaged muscles. Medical directors of the physical medicine and rehabilitation departments, Orange County General Hospital, enlisted help from the dietary department in the initial experiment, which has become a regular therapy activity. Staff members, volunteers, and outside groups donated much of the equipment; volunteers aid patients in organizing work, giving assistance when needed. Projects undertaken by the approximately 100 patients participating in the program in the last 1½ years are described briefly.

See also 798.

# HYDROCEPHALUS

772. Society for Research into Hydrocephalus and Spina Bifida (Gt. Brit.)

(Digest of proceedings of annual meeting, June 23-24, 1961). *Lancet.* Aug. 5, 1961. 7197:295-297.

Current research in the medical aspects and treatment of hydrocephalus and spina bifida was reported at the Society's annual meeting in Edinburgh. Dr. K. M. Laurence (Cardiff) estimated 46% of those with hydrocephalus survive, 30% are educable, and only about 14% physically and mentally normal. Dr. T. T. S. Ingram (Edinburgh) described pediatric aspects of cerebral palsy associated with hydrocephalus; in the last 700 cases he had analyzed, 3.7% of patients had enlarged heads (cases of arrested hydrocephalus).

Statistics on incidence of spina bifida indicated the condition was substantially more frequent in first pregnancies; environment apparently played a greater part than heredity or chance mutation in etiology. The mechanism of paralytic deformity in spina bifida was discussed by Mr. J. W. Sharrard (Sheffield).

# HYPNOSIS

773. Rousey, Clyde L. (Speech Clinic, Humboldt State Coll., Arcata, Calif.)

Hypnosis in speech pathology and audiology. *J. Speech and Hear. Disorders.* Aug., 1961. 26:3:258-267.

A literature review shows that, with few exceptions, case reports and research studies failed to take into account relevant variables in either hypnosis or speech and hearing. Various levels of hypnosis are not used in any systematic way to describe hypnotic conditions under which positive suggestions were given or improvement



## ABSTRACTS

seemed to be most pronounced. Possible applications of hypnosis to both clinical and theoretical aspects of speech and hearing disorders can be inferred, however. Advances in therapy by use of hypnosis with resistive persons may allow greater services in speech rehabilitation. 43 references.

### MENTAL DEFECTIVES

774. Blatt, Burton (*Special Education Dept., Southern Connecticut State Coll., New Haven, Conn.*)

Towards a more acceptable terminology in mental retardation. *Training School Bul.* Aug., 1961. 58:2:47-51.

The new definition of mental retardation, appearing in the American Association on Mental Deficiency manual on terminology and classification (see *Rehab. Lit.*, Dec., 1959, #885), does appear to describe more adequately the nonorganic "familial" child. However, used as a comprehensive term, the definition does have practical weaknesses that are both important and obvious, the writer believes. Three of the most significant weaknesses, from the educator's point of view, are outlined with recommendations for changes in terminology that may contribute to clearer agreement on the definition.

See also 737; 808; 815.

### MENTAL DEFECTIVES—WASHINGTON

775. Washington. Governor's Inter-Agency Committee on Health, Education, and Welfare Programs

*Everybody's child, the mentally retarded; report of the Subcommittee on Mental Retardation to the . . . Olympia, The Committee, 1961. ix, 18 p.*

Major recommendations included: the establishment of a state mental retardation center, directed by an inter-agency board, to conduct research and professional education and provide diagnostic and consultative services for regional and local centers and private clinics. A public health approach in both community and clinic studies of mental retardation was suggested. Other means of meeting the growing problem concerned preventive measures to decrease the incidence of birth defects and prematurity, multidisciplinary education of all professional personnel working with the mentally retarded, and long-range planning to provide increased community services and residential facilities for the retarded of all ages.

The report is distributed by the Washington State Dept. of Health, Smith Tower, Seattle 4, Wash.

### MENTAL DEFECTIVES—EMPLOYMENT

776. Edgerton, Robert B. (*Pacific State Hosp., Pomona, Calif.*)

Free enterprise in a captive society, by Robert B. Edgerton, George Tarjan, and Harvey F. Dingman. *Am. J. Mental Deficiency.* July, 1961. 66:1:35-41.

A report of a series of observations on a traditional practice—car washing by patients—at Pacific State Hospital. Patients and long-term employees regarded it as a practical and advantageous activity, newer employees as a somewhat more therapeutic endeavor. Patients wanting money and capable of washing cars are motivated to substantial effort, taking the initiative in seeking customers and establishing an industry within the hospital environ-

ment. Success can result in preferential vocational assignments and other benefits. The activity strongly resembles competitive business. This study is part of a major project in which social anthropological studies are being conducted on some traditional practices at the hospital.

777. The mentally retarded. *Rehab. Record.* July-Aug., 1961. 2:4:9-26.

Contents: Positive approach needed, Burton Blatt.—Smoothing the transition, Robert G. Ferguson.—Demonstrating "job ability," H. T. Gragert.—Evaluation's goal: prediction or elimination? Michael M. Galazan.—Guides to cooperation, Max Dubrow.—New York's work-study program, Sol Richman and William C. Spinelli.—Johnstone's 5-phase training, Joseph J. Parnicky (and others).—An employer's view, Mrs. William C. Templeton, Jr.

Vocational rehabilitation programs provided by the locally supported sheltered workshop, Goodwill Industries, state training school, and state division of vocational rehabilitation are discussed by Dr. Ferguson, Mr. Gragert, Mr. Richman and Mr. Spinelli, and Dr. Parnicky and his staff members. Dr. Blatt disproves many of the negative and false assumptions concerning vocational potential of the retarded. Mr. Galazan discusses differences in the evaluation of mentally retarded persons and those with normal capacity. Mrs. Templeton, Jr., relates problems of mentally retarded employees and factors that limit their usefulness.

### MENTAL DEFECTIVES—PROGRAMS

778. Fraenkel, William A.

*The mentally retarded and their vocational rehabilitation; a resource handbook.* New York, Natl. Assn. for Retarded Children, 1961. 87 p.

This booklet, prepared at the request of the U.S. Office of Vocational Rehabilitation as an aid to counselors, points out community resources available and the cooperative efforts that can result in job placement for a larger number of mentally retarded. Operational plans the counselor may want to consider in work with the retarded are outlined, with criteria for determining eligibility and feasibility for rehabilitation services. Brief mention is made of a variety of training programs currently operating in the U.S. Also covered are specific problems counselors may encounter in working with the retarded, technics to use in their solution, and long-term counseling that may be required in some cases. 73 references.

Available from National Association for Retarded Children, 386 Park Ave. S., New York 16, N. Y.

### MENTAL DEFECTIVES—PSYCHOLOGICAL TESTS

779. Lyle, J. G. (*Dept. of Mental Hygiene, Victoria, Austral.*)

Comparison of the language of normal and imbecile children. *J. Mental Deficiency Res.* June, 1961. 5:1:40-51.

From the 2 investigations reported here, it is clear that the imbecile children were developmentally retarded. Retardation on various speech and language tests seemed to be due partly to lower terminal achievement and partly to a slower rate of verbal development. The more primitive language characteristics were used almost exclusively by the imbeciles; this is explained in terms of inherent de-

fects of higher level cortical functioning. Environmental effects were evident in the finding that significantly more institutionalized imbeciles used the earliest of language categories than did imbeciles attending day schools. (See *Rehab. Lit.*, Sept., 1960, #659.)

780. Lyle, J. G. (*Dept. of Mental Hygiene, Victoria, Austral.*)

Some personality characteristics of "trainable" children in relation to verbal ability. *Am. J. Mental Deficiency*. July, 1961. 66:1:69-75.

Previously observed differences in verbal ability between trainable children at day schools and in institutions (see *Rehab. Lit.*, Sept., 1960, #659) could not be explained in terms of personality differences investigated in the research project reported here. Personality ratings on variables of physical activity, emotionality, assertiveness, timidity, dependence, nervous mannerisms, and distractibility were obtained for 194 testable imbeciles attending Fountain Hospital (*London*) training center and Middlesex Day Schools. Differences between mongoloids and nonmongoloids were also studied. It is suggested that nonverbal mental age and chronological age and mongolism would be much better predictors of verbal achievement than any of the variables examined here.

See also 749; 799.

#### MENTAL DEFECTIVES—RESEARCH

781. Stolurow, Lawrence M. (*Dept. of Psychology, Univ. of Illinois, Urbana, Ill.*)

Research on mental deficiency at the Institute for Research on Exceptional Children, University of Illinois. *Training School Bul.* Aug., 1961. 58:2:61-73.

In same issue: Description of NIMH-sponsored research programs at Pacific State Hospital, Harvey F. Dingman. p. 74-79.

Two major sociological problems and 3 psychological studies currently of concern to staff of the Institute for Research on Exceptional Children are discussed. Studies of the effect of the retarded child on the family, of social organization within wards at state institutions for the retarded, of achievements of special class training as compared to development of educable children in regular classes, of the usefulness of self-instructional devices (teaching machines), the development of a test of psycholinguistic abilities, and research on programing principles are activities within the total program relating to mental deficiency.

Dr. Dingman (*Pacific State Hosp., Pomona, Calif.*) discusses 2 federally supported research projects at Pacific State Hospital—the Population Movement Study (see *Rehab. Lit.*, Mar., 1961, #208, for earlier references) and the Data Processing Laboratory, which should eventually provide valuable information on patient care and efficient hospital operation.

#### MENTAL DEFECTIVES—SPECIAL EDUCATION

782. Burns, Paul C. (*Univ. of Kansas, Lawrence, Kan.*)

Arithmetic fundamentals for the educable mentally retarded. *Am. J. Mental Deficiency*. July, 1961. 66:1:57-61.

The author outlines a 4-level sequence program suitable for instructing educable retardates; no information is

included on methods and materials of instruction, however. The teacher should consider each item in regard to its importance to students, how it may be presented in a concrete way, and how skills can be practiced enough to assure real learning.

783. Mein, R. (*Harperbury Hosp., St. Albans, Herts., Eng.*)

A study of the oral vocabularies of severely subnormal patients: II. Grammatical analysis of speech samples. *J. Mental Deficiency Res.* June, 1961. 5:1:52-59.

A report of investigations of severely subnormal patients' responses during conversational interviews and in picture descriptions. An attempt was made to determine whether such persons follow the same developmental pattern in language growth as do normal children, although at an age later than for normal children. The progressive drop in percentage of nouns used as mental level increases among the subnormal was consistent with that found in maturing language of normal children. Significant differences in the use of nouns and articles between matched pairs of mongols and nonmongols were observed. If noun percentage may be accepted as a gross indicator of developmental level, it is possible to conclude that mongols function at a lower level than nonmongols. However, their individual classified and unclassified vocabularies were the same.

784. Peck, John R. (*Univ. of Texas, Austin, Tex.*)

Effect of various settings on trainable children's progress, by John R. Peck and C. Lucille Sexton. *Am. J. Mental Deficiency*. July, 1961. 66:1:62-68.

A summary of a Cooperative Research Project completed at the University of Texas in 1959; comparisons of the social adjustment and learning achieved by 35 young trainable mentally retarded children in 4 locations were made. Three groups of 9 each attended training classes in a public school, parent-sponsored day center, or state institution (residential school). The fourth group was taught only at home. Those in training programs made significantly more progress than those taught at home; progress was more marked during the first year of the 2-year program. The Illinois plan for trainable children was used as the framework of the curriculum, modified or expanded as necessary. An important concomitant of the research was the development of an exhaustive long-range curriculum that will be published at a later date, along with the full rating scale, as a manual for teachers.

#### MENTAL DEFECTIVES—SPEECH CORRECTION

785. Rigrodsky, Seymour (*The Training School, Vineland, N.J.*)

Language behavior of a group of non-speaking brain-damaged mentally retarded children, by S. Rigrodsky and S. Goda. *Training School Bul.* Aug., 1961. 58:2:52-60.

A report of an investigation of the means and methods used by nonspeaking children to express their wants and needs; subjects were institutionalized mentally retarded children reported as having, or suspected of having, brain damage. A wide range in ability to utilize and comprehend verbal and gestural language was observed both during free play periods and in structured test situations, with the greatest sound production occurring during free

## ABSTRACTS

play. Four levels of receptive language ability and 5 developmental levels for expressive language are outlined. Case descriptions of children classified under the communicative schema are included. Data suggest that the measured intelligence would appear to be highly related to level of comprehension. A language questionnaire completed by teachers and houseparents evaluated language behavior on levels observed in free play situations. Findings indicate a need for language stimulation programs in both the cottage and classroom.

**786. Rigrodsky, Seymour** (*The Training School, Vineland, N.J.*)

Mowrer's theory applied to speech habilitation of the mentally retarded, by Seymour Rigrodsky and M. D. Steer. *J. Speech and Hear. Disorders*. Aug., 1961. 26:3:237-243.

Effectiveness of traditional auditory stimulus technics of speech therapy and an experimental articulation therapy technic (based on Mowrer's Autistic Language Development Theory) was compared in a study of 72 institutionalized retardates. Children in the experimental group appeared to become more spontaneously verbal and were more favorably disposed toward therapy and the clinician than children receiving traditional therapy programs. This study was judged a very satisfactory test of the efficacy of the experimental approach to speech habilitation with retardates; it is one of the few completed control studies of the value of different technics.

## MENTAL DISEASE—EMPLOYMENT

See 819.

## MUSCULAR ATROPHY

**787. Byers, Randolph K.** (300 Longwood Ave., Boston 15, Mass.)

Infantile muscular atrophy, by Randolph K. Byers and Betty Q. Banker. *Arch. Neurol.* Aug., 1961. 5:2:140-164.

Infantile muscular atrophy in 52 patients observed over a 11-year period is reviewed to illustrate the variability in clinical and pathological severity and the nature of the pathology. Genetic, diagnostic, and therapeutic aspects are discussed; data support the concept of transmission of the disease by an autosomal recessive gene. It is the authors' opinion that infantile muscular atrophy and amyotrophic lateral sclerosis are not the same disease in children. The usefulness of the usual clinical laboratory procedures and muscle biopsy in diagnosis is stressed. 25 references.

## MUSCULAR DYSTROPHY— PSYCHOLOGICAL TESTS

**788. McCully, Robert S.** (New York Hosp., 525 E. 68th St., New York 21, N.Y.)

Human movement in the Rorschach materials of a group of pre-adolescent boys suffering from progressive muscular loss. *J. Projective Techniques*. 1961. 25:2:205-211.

Characteristics of the M responses to Rorschach testing in 16 boys with childhood muscular dystrophy, attending a day care school operated by New York City Public Schools in Payne Whitney Clinic, were investigated. The

relationship between motor activity and the M response, as well as the psychological meaning of such responses, was considered. Findings support the idea that restriction of movement may be related to production of M responses, although the relationship may be superficial. In dystrophic children, production of M responses is, perhaps, more related to the psychological meaning to the self of the motor loss rather than to the motor restriction itself. The preponderance of M responses in the group corresponds with the presence of an active fantasy life; exceptions suggest, however, that presence or absence of M can have no relation to the extent of fantasy life per se. (For additional discussion of the group's reactions to their physical disability, see *Rehab. Lit.*, Mar., 1961, #220.)

## MUSCULAR DYSTROPHY— SPEECH CORRECTION

**789. Mullendore, James M.** (109 New Cabell Hall, Univ. of Virginia, Charlottesville, Va.)

Speech patterns of muscular dystrophic individuals, by James M. Mullendore and Ralph J. Stoudt, Jr. *J. Speech and Hear. Disorders*. Aug., 1961. 26:3:252-257.

Describes procedures used to measure hearing, gross movement of the articulatory organs, phonation, and articulation of 31 patients. Four types of muscular dystrophy are classified and the speech problems in the different forms are discussed. Except where musculature of the lips was involved, the dystrophic condition was not observed to present any consistent pattern of articulation errors. The high incidence of errors, however, suggests they are not truly functional articulatory defects but are more related to the onset and progress of the dystrophic process. Application of speech therapy with muscular dystrophy patients was not studied, but therapy for patients with the more slowly progressive types of muscular dystrophy might be highly beneficial.

## MUSIC THERAPY

**790. Montgomery, Marcelle S.** (Oregon Soc. for Crippled Children and Adults, 200 Orton Bldg., 1135 S.W. Yamhill St., Portland 5, Ore.)

Functional gym. *Phys. Therapy Rev.* Aug., 1961. 41:8:578-581.

A functional activities program, conducted by the Oregon Society for Crippled Children and Adults' Mobile Therapy Clinic at the Children's Hospital School in Eugene, tests use of skills, provides group and teamwork experience, and stimulates more rapid body movements to the rhythm of piano music. Opportunity to develop ability to dress and undress in a practical way is also provided. The sequence of gym activities is discussed. Results achieved are tabulated. Children with spasticity appeared to respond best to musical rhythms.

## NEUROLOGY

**791. Glaser, Gilbert H.** (333 Cedar St., New Haven, Conn.)

Spasticity and spasms in hemiplegia and paraplegia. *Cerebral Palsy Bul.* Aug., 1961. 3:4:349-354.

Differences between spasticities appearing in hemiplegia due to supraspinal lesions and in paraplegia due to spinal lesions are explained. In hemiplegia spasticity

## REHABILITATION LITERATURE



is characterized by extensor predominance in the lower extremity and flexor predominance in the upper. In spinal paraplegia spastic lower extremities are usually in flexion; extension is occasionally present, more so with incomplete spinal lesions. Spasms, spontaneous or induced by a variety of stimuli, have a similar distribution in both conditions. General physiological mechanisms of spasms are considered.

792. Walton, John N. (*Newcastle Gen. Hosp., Newcastle upon Tyne, Eng.*)

The prognosis and management of some muscular diseases. *Annals Phys. Med.* Aug., 1961. 6:3:116-130.

Progressive muscular dystrophy, related disorders, and muscle diseases in which myotonia is a prominent symptom or physical sign—polymyositis, myasthenia gravis, familial periodic paralysis, and McArdle's syndrome—are discussed from the standpoint of drug therapy, physical medicine, and prognosis. The paper does not include discussion of congenital myopathies, some of which produce or are associated with infantile hypotonia.

793. Wynn Parry, C. B.

*Peripheral neuropathies; the Louis G. Horowitz Lecture for 1960.* New York, Institute of Phys. Medicine and Rehabilitation, 1961. 43 p. tabs. (*Rehab. monograph XVIII*)

In his review of peripheral neuropathies from the standpoint of etiology and diagnosis, Dr. Wynn Parry offers 2 classification schemes—one by etiology, the other by level of lesion in the lower motor neuron. He notes advances in electrodiagnosis and discusses some of the causes of peripheral neuropathies, chosen for the light they shed on the reaction of the lower motor neuron to disease. Some causes may afford a clue to an underlying disease, such as carcinoma, or to new syndromes in common diseases, now better recognized. The literature is reviewed and possible avenues for future research are suggested. Dr. Wynn Parry is principal specialist in physical medicine to the Royal Air Force and in charge of electromyography at London Hospital. His duties involve clinical control of rehabilitation units and physical medicine departments of Royal Air Force hospitals, training of rehabilitation personnel, and research in physical medicine and rehabilitation. He is author of the book *Rehabilitation of the Hand*, reviewed in *Rehab. Lit.*, Jan., 1960, p. 13.

The first two Horowitz lectures were published together in the Institute's *Rehabilitation monograph* 17 (see *Rehab. Lit.*, July, 1960, #532).

Available from the Institute of Physical Medicine and Rehabilitation, 400 E. 34th St., New York 16, N.Y., at \$1.00 each.

## NURSING—STUDY UNITS AND COURSES

794. Robinson, Glendora (*Crawford W. Long Memorial Hosp., 35 Linden Ave. N.E., Atlanta 8, Ga.*)

Student nurses learn rehabilitation. *Rehab. Record.* July-Aug., 1961. 2:4:40.

An instructor in orthopedic nursing briefly describes a teaching unit, introduced at Crawford W. Long Memorial Hospital, Atlanta. Students have shown increased interest in rehabilitation nursing and have been able to utilize material from this course in many other areas of

nursing. The course includes a review of communication skills and patient teaching, body alignment, preparation for walking, range-of-motion exercises, rehabilitation of patients with a cast, brace, or crutches, types of crutches and crutch gaits related to orthopedic conditions. Facilities of the state vocational rehabilitation agency available to patients are discussed. A unit of rehabilitation nursing, broader in scope, is being planned for freshman students as part of the course in fundamental nursing. Similar units have been established in 2 other Atlanta hospital schools of nursing.

## OLD AGE

See 741; 764; 802; 813.

## OLD AGE—MEDICAL TREATMENT

795. Olejniczak, Stanley (*Wayne County Gen. Hosp., Eloise, Mich.*)

Common problems of the aged in physical medicine and rehabilitation in a county hospital. *J. Mich. State Med. Soc.* July, 1961. 60:7:893-898.

Commonly encountered problems of aged persons related to physical medicine and some everyday nursing problems in both the general hospital and infirmary of Wayne County General Hospital are discussed. Included are: management of the elderly amputee, prevention and treatment of flexion contracture deformities of neuromusculoskeletal diseases, care and prevention of decubitus ulcers, and training for bowel control. Early institution of a physical rehabilitation program for elderly patients is vital; those with potential for some rehabilitation should be screened by a physiatrist before being sent to nursing or convalescent homes for custodial care. An earlier article by the author (see *Rehab. Lit.*, Jan., 1958, #110) described the over-all program of physical medicine and rehabilitation at the hospital, serving 3,500 psychiatric patients, 500 acutely ill in the General Hospital Division, 800 chronically ill, and 1,800 ambulatory indigent in the Infirmary Division.

See also 758.

## OLD AGE—OCCUPATIONAL THERAPY

796. *Am. J. Occupational Ther.* July-Aug., 1961. 15:4.

Entire issue devoted to the subject.

Contents: The role of the occupational therapist in the care of the geriatric patient, Mary V. Diamond and Patricia Laurencelle, p. 139-141, 175.—The cultural evening program, Carolyn B. Aggarwal and Marilyn Bibb, p. 142-144.—A state occupational therapy program for the aged, Mary Schroepfer, p. 145-148.—Training personnel where you find them, John A. Hackley, Janet B. Chermak, and Richard C. Wright, p. 149-151.—Nursing homes want activity programs, Evelyn Bengson, p. 152, 175.—Occupational therapy for the aged psychiatric patient, Hazel C. Tendo, p. 153-156.—A training program for occupational therapy assistants, Virginia Louise Caskey, p. 157-159.—Occupational therapy in homes for the aged, Janet Crawford and Helen Strehlow, p. 160-161, 175.—Queries and answers: Geriatrics, p. 162, 175-176. Reports from the White House Conference on Aging, p. 164-169, 175.

## ABSTRACTS

### OLD AGE—PHYSICAL THERAPY

797. Stiebel, P.

In praise of geriatrics. *Physiotherapy*. Aug., 1961. 47:8:209-210.

Three years' experience as a physical therapist working with hospitalized geriatric patients has convinced the writer that rewards of this type of service are great; with the right approach achievements are remarkable, considering the advanced age and severity of disability in patients. Some techniques used in rehabilitating hemiplegics and those with knee flexion contractures, or fused hip joints, are mentioned.

### PHYSICAL EFFICIENCY

798. Asmussen, Erling (*Testing and Observation Institute, Danish Natl. Assn. for Infantile Paralysis, Tugborgej 5, Hellerup, Den.*)

A new test for estimating fitness for housework, by Erling Asmussen (and others). *Communications, Testing and Observation Institute, Danish Natl. Assn. for Infantile Paralysis*. 1961. 10:3-9.

This test supersedes one devised in 1958, described in the Institute's *Communication no. 1*. Principles upon which the procedures are based are described in an earlier communication (see *Rehab. Lit.*, Aug., 1961, #651). Working capacity of the handicapped housewife can be expressed as a percentage of the capacity of the non-handicapped. Testing requires about 4 hours and consists of 3 groups of activities including housecleaning, meal preparation, and laundering. Sample tables illustrating recording of data and analysis of capacity in the case of a handicapped housewife are included.

The *Communications* are issued irregularly and are available from the Association at the above address on request, as long as the supply lasts.

799. Smith, Judith Roser (*Institute of Child Development and Welfare, Univ. of Minnesota, Minneapolis 14, Minn.*)

The relationship of motor abilities and peer acceptance of mentally retarded children, by Judith Roser Smith and John G. Hurst. *Am. J. Mental Deficiency*. July, 1961. 66:1:81-85.

The relationships between motor ability, measured by the Lincoln-Oseretsky Motor Development Scale, and peer acceptance, measured by direct observation techniques, were investigated in 18 trainable and 25 educable mentally retarded children attending Sheltering Arms, a research center and day school in Minneapolis. The relative consistency of results in the two groups supports the hypothesis that motor ability, as defined in the study, plays a significant role in peer acceptance, as defined for these children. Motor ability, with M.A. and C.A. held constant, had significant Beta coefficients for its regression on total child contacts, verbal contacts, and received contacts for both groups of children.

### PHYSICAL EXAMINATION

800. American Medical Association. Committee on Medical Rating of Physical Impairment (535 N. Dearborn St., Chicago 10, Ill.)

Guides to the evaluation of permanent impairment: ear,

nose, throat, and related structures. *J. Am. Med. Assn.* Aug. 19, 1961. 177:7:489-501.

This guide and the three published previously (see *Rehab. Lit.*, Apr., 1958, #439; Dec., 1958, #1337; and May, 1960, #348) all contain recommended percentage values related to the criteria provided. Methods of calculating impairment are uniform, explained in detail with examples, and require a minimum of computation. These guides also are intended to clear up past confusion of terms. Specific instructions on examination procedures are included.

Earlier guides dealt with evaluation of the extremities and back, the visual system, and the cardiovascular system.

801. Denman, Frank R. (309 Hermann Professional Bldg., Houston 25, Tex.)

Pre-employment roentgenography of the back, by Frank R. Denman, Joe R. Gandy, and William R. Hampton. *Texas State J. Med.* Aug., 1961. 57:8:704-706.

An appraisal of methods of medical control in reducing frequency, severity, and costs of disabilities resulting from back injuries led to the conclusion that careful pre-employment history and physical examination, with roentgenography of the back only when the physician deems it necessary, would be as effective in screening potential cases of disability as routine roentgenography of the back. Analysis of the records of 343 patients admitted to Southern Pacific Hospital during the period 1945-1956 because of back injury showed 44% had normal roentgenograms on admittance. Regardless of pre-employment roentgenographic findings, fractures and back surgery, namely laminectomies and spinal fusions, accounted for the longest hospitalization periods. All of these were attributed to disc disease or major trauma and were considered unpreventable by any pre-employment examination. Adequate supervision and instruction in proper and safe performance, it is believed, would prevent more disability of this type than any other method of control.

802. Steiner, Louis J. (2799 W. Grand Blvd., Detroit, Mich.)

Problems of the aging worker as viewed by: III. The disability examiner. *Indust. Med. and Surg.* Aug., 1961. 30:8:316-319.

Disability evaluation is not an exact science; reports of clinical examinations for evaluation of medical impairments must be factual, relatively recent, and definite and clear if disability programs and pension plans are to be administered satisfactorily. The effect of impairment on the individual's functional capacity is the real test of total disability, but other factors, some not strictly medical, may enter into the evaluation. The roles of the private physician and the disability examiner are defined.

This paper is one of 3 from a panel discussion presented at the 1961 Michigan Industrial Medical Association meeting held in Detroit in March, 1961. Others appearing in this issue are: Problems of the aging worker as viewed by: I. The private physician, A. Hazen Price, p. 310-312.—II. The industrial engineer, L. J. Langton, p. 313-315.

### PHYSICAL MEDICINE

803. Shands, A. R., Jr. (Alfred I. duPont Institute, Rockland Rd., Wilmington 99, Del.)

A few remarks on physical medicine, rehabilitation, and

orthopedic surgery. *South. Med. J.* Apr., 1961. 54:4: 420-425.

Dr. Shands traces the development of physical medicine and rehabilitation as a specialty field, its effect on the practice of orthopedic surgery, and the relationship between physiatry and other fields of medicine. The resulting division of responsibility between orthopedic surgery and physical medicine and rehabilitation has confused the patient; the amalgamation of the two specialties might be desirable. Leaders in both specialties must work in close association to provide the rehabilitation programs needed for total patient care.

## PHYSICAL THERAPY

See 736; 790.

### PHYSICAL THERAPY—PERSONNEL

804. The shortage of physiotherapists: I. The administrator's point of view, R. C. Millward; II. Work study, D. T. Bell; III. The use of non-physiotherapy personnel, C. M. Hay. *Physiotherapy*. Aug., 1961. 47:8:211-218.

Mr. Millward, responsible for administration of general hospitals of varying size, recommends management training centers for physical therapists, work studies of the operation of physical therapy departments, and closer cooperation between medical staff and physical therapy department as the means for promoting more efficient use of physical therapy staff time and facilities. Miss Bell, superintendent physiotherapist (*Stoke Mandeville Hosp., Aylesbury, Bucks., Eng.*), discusses findings, to date, of a work-study investigation being conducted in her department. An indirect advantage of such studies is that staff are made conscious of problems and often can offer solutions that are timesaving. Miss Hay, superintendent physiotherapist (*Worthing Hosp., Sussex, Eng.*), urges greater use of nonprofessional personnel in the performance of duties that are nonprofessional and time consuming. The use of student nurses in the department is illustrated.

The 3 papers were presented at the annual conference of the Institute of Hospital Administrators (*Gt. Brit.*) held in May, 1961.

### POLIOMYELITIS

See 763.

### PREGNANCY

805. Ten Berge, B. S. (*University Hosp., Groningen, The Netherlands*)

The influence of the placenta on cerebral injuries. *Cerebral Palsy Bul.* Aug., 1961. 3:4:323-331.

Prospective investigations and follow-up studies, conducted at the Obstetric Clinic, University of Groningen, since 1954, revealed neurological abnormalities in 38 of 60 children who had presented symptoms of neonatal hypoxia. Follow-up 1 1/4 to 4 years later confirmed the belief that hypoxia was the main cause of permanent neurological disturbances. If prenatal care is to be improved, more attention should be directed to the anatomy and function of the placenta, and especially to fetal circulation. Recommendations for improving obstetric procedures during delivery are offered.

The editorial on p. 317, "The choreiform syndrome and other work done by Heinz Prechtel," discusses findings of Dr. Prechtel and his colleagues at the University of Groningen. The syndrome, observed in numerous children first referred because of behavioral difficulties in school, is not seen before the age of 3. Studies of the normal population in the area by Dr. Prechtel have demonstrated the syndrome in 20% of boys and 9% of girls; the incidence of 14% has been confirmed by several independent observers. It appears likely that "minimal brain damage" contributes to far more of these behavioral problems than has previously been supposed. The *Bulletin* will carry, in a later issue, an article by Dr. Prechtel on the choreiform syndrome.

### PUBLIC HEALTH NURSING

#### 806. National League for Nursing

*Criteria for evaluating the administration of a public health nursing service.* New York, The League, 1961. 36 p.

Criteria to be used in identifying elements of administration basic to the provision of a public health nursing service are offered as a guide in studying the administrative framework within which effective programs can be developed. In no case is the guide to be considered as an inflexible measuring instrument; the extent to which an agency is making progress in meeting the criteria should be considered. Persons contracting for services should find the 16 criteria useful in discussions with agency personnel. Each of the 16 points is considered separately, with amplification and references keyed to a complete bibliography at the end of the pamphlet. Main objective in publishing the criteria is the improvement of public health nursing. A shortened version of the pamphlet is reproduced without the keyed references in *Nursing Outlook*, Aug., 1961 (9:8:500-502); the complete bibliography is included, however.

Available from National League for Nursing, Dept. of Public Health Nursing, 10 Columbus Circle, New York 19, N.Y., at 25¢ a copy (less in quantity orders).

### REHABILITATION

807. Newman, Louis B. (333 E. Huron St., Chicago 11, Ill.)

Dignified living for the severely disabled; the role of physical medicine and rehabilitation, by Louis B. Newman, Robert S. Wilson, and Joseph S. Stratigos. *Quart. Bul.*, Northwestern Univ. Med. School. Spring, 1961. 35:1: 61-69.

Dr. Newman outlines services and staffings of physical medicine and rehabilitation departments in VA hospitals, fundamental rehabilitation principles and categories of rehabilitation procedures, and the basic objectives of total rehabilitation. Types of therapeutic exercises are explained briefly. A case history, illustrating the value of intensive physical medicine and rehabilitation services co-ordinated with medical, surgical, orthopedic, and other services of the hospital, is included. Dr. Newman emphasizes the necessity of medically prescribed, directed, and supervised physical medicine and rehabilitation services, initiated early, intensively, and for a sufficient length of time to insure minimum residual impairment.



## ABSTRACTS

### REHABILITATION—NEW YORK

#### 808. New York. State Joint Legislative Committee on Mental Retardation and Physical Handicap

*Annual report, March 15, 1961.* Albany, The Committee, 1961. 61 p. illus., graphs. (*Legislative document* (1961) no. 7)

A resolution adopted by the Legislature in 1960 broadened the Committee's responsibilities to include investigation and study of public problems related to cerebral palsy, epilepsy, emotional disturbance, and brain damage. A summary of the Committee's legislative proposals during 1961 and its legislative record from 1955 through 1960 is given, with testimony offered by official spokesmen for groups of children with various handicaps, providing background information on specific physical handicaps and unmet needs. Advances in programs of care and education, made during 1960, are reported briefly by the state departments of Mental Hygiene and of Education. Data on special classes, number of children served, and number of public school units providing classes for trainable retardates are included; a county breakdown by school districts indicates the number of classes for educable and trainable in each district.

Issued by Earl W. Brydges, Chairman, N.Y. State Joint Legislative Committee on Mental Retardation and Physical Handicap, Room 504, State Capitol, Albany, N.Y.

### REHABILITATION—PENNSYLVANIA

#### 809. Pennsylvania. Governor's Committee for the Handicapped (Room 371, Education Bldg., Harrisburg, Pa.)

*Proceedings of the First Pennsylvania Conference of the . . . November 21-22, 1960 . . . Harrisburg . . . co-sponsored by the . . . and the Alfred I. duPont Institute of the Nemours Foundation. . . n.p., The Committee (1961?).* 72 p.

The first statewide conference was the culmination of 2 years' co-operative efforts to improve services to the handicapped through regional hearings and emphasis on local needs. Discussion and papers covered information on quantity and quality of current services in Pennsylvania, recommendations for additional or new types of service, and reports from 8 communities where local Councils for the Handicapped have been established.

Addresses included: Keynote address, Hon. John Morgan Davis.—The conscience of the Commonwealth, Samuel M. Wishik.—The new vitality in local government; a lesson from the handicapped, Hon. George M. Leader.—Community action for adults with disabilities, Darrel J. Mase.—Concluding remarks, A. R. Shands, Jr., and Pearl S. Buck (chairman of the Governor's Committee).

### REHABILITATION—PERSONNEL

See 739; 804; 806.

### REHABILITATION—PROGRAMS

#### 810. Internat. Child Welfare Rev. 1961. 15:2:71-160.

Title of issue: The care of handicapped children of pre-school age.

Preliminary reports and conclusions of the first plenary meeting of the Advisory Committee on Medico-Social

Questions of the International Union for Child Welfare, held in May, 1961, at Leysin, Switzerland.

Contents: Editorial.—Introductory report, Bea van den Berg.—The handicapped child; provisional classification with regard to rehabilitation (Austria).—Comments on the rehabilitation of handicapped children (Netherlands).—The role of maternity and child welfare organizations (Germany).—Treatment at home or in specialized institutions? (Italy).—Qualifications and training of personnel (Belgium).—Mental health and upbringing of the handicapped child (Switzerland).—The mental health of the handicapped child (Spain).—Conclusions.—Bibliography.

Separate numbers of the *Review*, on special subjects, can be purchased from International Union for Child Welfare, 1, rue de Varembe, Geneva, Switzerland, at Sw. frs. 3 per copy.

#### 811. White, Esther (*Soc. Service Dept., Mt. Sinai Hosp., 5th Ave. & 100th St., New York, N.Y.*)

The role of the community in rehabilitation. *Soc. Casework*. July, 1961. 42:7:332-338.

Experience with patients at the Jack Martin Poliomyelitis and Rehabilitation Center, Mt. Sinai Hospital, New York City, showed clearly that, if facilities for restoration are not available in the community for the discharged patient, total rehabilitation fails. Two case examples are used to illustrate the value of interagency co-operation within the community to achieve maximum rehabilitation. To accomplish the objectives, both the hospital program and the support provided by the community must be planned to meet individual needs. Suggestions for securing interagency co-operation and for planning realistic rehabilitation programs are offered.

### REHABILITATION—STUDY UNITS AND COURSES

#### 812. Prock, Valencia (*Western Reserve Univ., Cleveland, Ohio*)

A joint approach to education for the health professions. *Nursing Outlook*. Aug., 1961. 9:8:472-474.

Administration of the rehabilitation teaching program initiated at Western Reserve University in 1954 is discussed briefly. Its objective is to provide medical, nursing, and social work students with an understanding of the problems of chronic illness and the community resources available in patient care. Of the 3 types of conferences used, the patient-centered conference is considered most effective from the educational standpoint. The author, public health nurse assigned to the program, will describe her role as a member of the teaching staff in a second article, to appear in the September issue of *Nursing Outlook*. For a complete account of the development of the program and experiences of individual members of the teaching staff, see the group report published in November, 1959 (*Rehab. Lit.*, June, 1960, #391).

### REHABILITATION CENTERS—ADMINISTRATION

#### 813. Baulne, G., Sister (*Holy Ghost Hosp., 1575 Cambridge St., Cambridge 38, Mass.*)

Rehabilitation at Holy Ghost Hospital, Cambridge, Mass. *Hosp. Progress*. July, 1961. 42:7:22.

In same issue: Restoration at Kenmore Mercy Hospital, Kenmore, N.Y., by Sr. Mary Patricia. p. 23-24.

The development of the rehabilitation department of Holy Ghost Hospital, a chronic disease facility, is described. Expanding from a physical therapy department begun in 1951, it now offers complete care for 46 inpatients as well as outpatient services in the new Cardinal Cushing Rehabilitation Unit. Emphasis of the program is on the geriatric patient; no time limit is set on the patient's stay in the program, the only requirement being progress.

Sister Mary Patricia (*Kenmore Mercy Hosp.*, 2950 Elmwood St., Kenmore 17, N.Y.) discusses administration of Mercy Rehabilitation Center, located within the general hospital. Effective technics in rehabilitation of elderly patients with varying needs are described; this type of care and guidance has an important place in the modern general hospital.

See also 763.

## SCOLIOSIS

814. Moe, John H. (*91 S. Seventh St., Minneapolis 2, Minn.*)

Changing concepts of the scoliosis problem. *J. Bone and Joint Surg.* June, 1961. 43-A:4:471-47.

In same issue: Stabilization of the collapsing spine, Alice L. Garrett, Jacquelin Perry, and Vernon L. Nickel. p. 474-484.—Correction of severe deformity of the cervical spine in ankylosing spondylitis with the halo device; a case report, George E. Freeman. p. 547-552.

Dr. Moe's editorial reviews the current status of treatment of scoliosis, pointing out advances in the field and the present concern of orthopedic surgeons with maintenance of the spinal correction achieved. He points out the success achieved at Rancho Los Amigos Hospital in stabilizing the collapsing spine in severely handicapped persons.

Dr. Garrett (*Rancho Los Amigos Hosp.*, Downey, Calif.) and her associates describe their work with patients with major respiratory deficits and paralytic collapsing spines, demonstrating the safety of major surgical procedures on such patients. Benefits of stabilization of the spine to patients previously considered beyond surgical help have been achieved.

Dr. Freeman, Jr. (*Vanderbilt Univ. Hosp.*, Nashville, Tenn.) presents a method of traction correction of severe deformity of the cervical spine resulting from ankylosing spondylitis. He reports a case in which the halo described by Perry and Nickel was used in conjunction with occipitocervical spine fusion under local anesthesia.

## SHELTERED WORKSHOPS

815. Cohen, Julius S. (*Edward R. Johnstone Training and Research Center, Bordentown, N.J.*)

A workshop operation within the framework of a state institution. *Am. J. Mental Deficiency.* July, 1961. 66: 1:51-56.

Steps in the development of a workshop program at Edward R. Johnstone Training and Research Center, a short-term residential training school for mentally retarded boys and girls between the ages of 12 and 20 years, are traced. Training benefits provided students and

the integration of the workshop within the total vocational training program are discussed. The occupational workshop within the vocational department of a state institution can function primarily as an industrial training unit for students returning to either competitive or sheltered employment in the community; the program simultaneously provides service for the institution and the community. (See also #777, this issue of *Rehab. Lit.*)

816. Connecticut Society for Crippled Children and Adults

*Proceedings of the First New England Regional Institute on Sheltered Workshops and Industrial Homebound Programs, April 16, 1961-April 20, 1961 . . .* sponsored by . . . and the Office of Vocational Rehabilitation . . . Arthur L. DuBrow, Institute Coordinator. Hartford, The Society, 1961. 84 p. tabs.

Contents: Preface, Arthur L. DuBrow.—Purpose of the Institute, Ralph W. Beckley.—Sheltered workshops, yesterday and today, William A. Massie.—A look at the sheltered workshops and industrial homebound programs in New England today, Arthur L. DuBrow.—Panel presentation: Referral and intake, Alice Moore, Marjorie Taylor, Emil Hartl, and Richard Hill.—Group discussions: Referral and intake.—The workshop's role in evaluation, Oscar Kurren.—Resource panel: The workshop's role in evaluation, Frank Greenberg, Francis A. Harding, J. Philip Chandler, Gerald Cubelli.—Labor's stake in sheltered workshops and homebound programs, Kenneth Pohlmann.—National Institute on Workshop Standards, William A. Hayes.—Contract procurement problems of sheltered workshops, Michael M. Dolnick.—Group discussion: Industrial programs for the homebound.

Distributed by Connecticut Society for Crippled Children and Adults, 682 Prospect Ave., Hartford 5, Conn.

See also 741; 777; 778.

## SHELTERED WORKSHOPS—COLORADO

817. Metropolitan Council for Community Service, Denver

*A study of sheltered workshops in the metropolitan area.* Denver, The Council, 1960. 44 p. Mimeo.

Together with: *A proposal for a sheltered workshop demonstration project*, prepared by Robert F. Hickman. Denver, The Council, 1961. 10 p. Mimeo.

Five facilities in the metropolitan area of Denver, considered to be sheltered workshops, were evaluated in a study requested by the Denver Mile High United Fund. Factual information on services offered, trades learned, type of work performed, wages, referral policies, characteristics of clients, organization and administration, budget, physical facilities, and evaluation of co-operative work with other sheltered workshops are included for Goodwill Industries, Laradon Hall (a facility for retarded children and young adults), United Cerebral Palsy Center, Rehabilitation for the Blind Workshop, and Utility Workshop (for new Americans and the emotionally disturbed). Six other facilities not considered sheltered workshops, in the true sense of the definition, are also discussed. The Study Committee offers recommendations for improving sheltered workshop programs. Appendixes contain additional statistical data and forms. The proposal for a demonstration project, to test the validity of the study's

## ABSTRACTS

recommendations and to eventually co-ordinate sheltered workshops' rehabilitation efforts, was drawn up for submission to the Office of Vocational Rehabilitation.

Available from Metropolitan Council for Community Service, Inc., 1550 Lincoln St., Denver 3, Colo., at \$1.25 a copy.

### SHELTERED WORKSHOPS—GREAT BRITAIN

818. Wigfield, M. E. (*St. Mary Abbots Hosp., London, Eng.*)

Vocational training for the cerebral palsied. *Cerebral Palsy Bul.* Aug., 1961. 3:4:355-363.

An analysis of 3 years' experience in training young adults with cerebral palsy at Sherrards Training Centre, the National Spastics Society's first vocational training center. Discussed are types of disability in 211 applicants, reasons for rejection of 67, the social, domestic, and technical problems of trainees, and placement results. Equipment, facilities, and administration of the residential sheltered workshop center are described. The findings have implications for the future planning of educational programs and medical treatment of the cerebral palsied.

### SHELTERED WORKSHOPS—NEW YORK

819. Black, Bertram J. (*Altro Health and Rehabilitation Services, 373 Park Ave. S., New York 16, N.Y.*)

Rehabilitation of post-psychotic patients by industrial workshop. *Diseases Nerv. System.* Apr., 1961. 22:4 (Suppl.): 125-128.

Altro's program for postpsychotic patients was among the first in the U.S. to make use of the sheltered workshop setting as a controlled industrial transitional environment in rehabilitating such patients. Mr. Black discusses types of patients served, the goals to be achieved, and the advantages of providing sheltered workshop services outside the mental hospital. The workshop in the community is not a substitute for custodial wards or the sheltered shop in the hospital.

### SOCIAL SERVICE

See 739.

### SPECIAL EDUCATION

820. International Society for Rehabilitation of the Disabled

*World frontiers in special education; proceedings of the International Seminar on Special Education: Improving educational opportunities for handicapped children around the world . . . West Point, N.Y., August 25, 26, and 27, 1960.* New York, The Society, 1961. 49 p.

The proceedings report includes addresses and summaries of 6 discussion groups at each session.

Contents: Preface, Keith S. Armstrong.—First International Seminar on Special Education, Donald V. Wilson.—The scope, philosophy, and objectives of special education, J. A. Richardson.—Improving educational opportunities for handicapped children around the world, Leonard W. Mayo.—Administration of special education programs; features from the Danish primary school's special education, I. Skov Jorgenson.—Special education in Japan, Satoru Izutsu.—Personnel in special education

programs, L. P. Patterson.—Counseling and guidance in special education, Aleksander Hulek.—Instruction in special education programs, Frances P. Connor.—Conference summary, Harley Wooden, Helen Holodnak, and Maurice Fouracre.

Available from the International Society for Rehabilitation of the Disabled, 701 First Ave., New York 17, N.Y., at \$1.00 a copy.

### SPEECH CORRECTION

821. Darley, Frederic L. (*Speech Clinic, East Hall, State Univ. of Iowa, Iowa City, Iowa*)

Age of first word; review of research, by Frederic L. Darley and Harris Winitz. *J. Speech and Hear. Disorders.* Aug., 1961. 26:3:272-290.

Age of appearance of the first word, usually considered to be an important diagnostic measure of language development, was reviewed as reported in 26 groups of children. From results of the studies, it appears the average child begins to say his first word by approximately one year; appearance of first word delayed beyond 18 months may indicate serious physical, mental, or hearing involvement. There is no evidence as yet that age of first word has any usefulness in predicting severity of articulation defectiveness at a later date. Research on the language learning process might attempt to analyze interpersonal events between mother and child leading to the child's first words.

822. Hahn, Elise (*663 Hanley Ave., Los Angeles 49, Calif.*)

Indications for direct, nondirect, and indirect methods in speech correction. *J. Speech and Hear. Disorders.* Aug., 1961. 26:3:230-236.

Where children resist correction or show hostility or indifference to the direct approach, the nondirective or indirect approach can help them overcome problems of self-understanding and adjustment and motivate the desire to communicate. Behavior of the child and factors in the case history should be studied to determine the best approach to needs of each child. Nondirective play therapy should not be undertaken, however, by an untrained person. By adapting the approach to therapy, speech correction becomes more than the teaching of articulation; its objectives are the improvement of language structure, the expression of feeling, and the purposive communication of ideas.

See also 773; 800.

### SPINA BIFIDA

See 772.

### STUTTERING

823. Kent, Louise Robison (*Speech and Hearing Clinic, Oklahoma State Univ., Stillwater, Okla.*)

Carbon dioxide therapy as a medical treatment for stuttering. *J. Speech and Hear. Disorders.* Aug., 1961. 26:3:268-271.

The literature is reviewed and results of a survey of opinion among American members of the Carbon Dioxide Research Association are summarized. Although the treatment is not used as commonly now as in the past, it is



still being employed by psychiatrists to treat stuttering. Replies of Meduna and Smith, who pioneered in carbon dioxide therapy, are discussed in more detail. The question of whether this form of therapy is a useful adjunct to speech therapy remains unanswered, as does the question of the influence of certain factors on the treatment's efficacy.

# SURGERY (PLASTIC)

824. Bulbulian, Arthur H. (*Mayo Clinic, Rochester, Minn.*)

Congenital malformation of the ear; prosthetic reconstruction in combination with a plastic surgical procedure, by Arthur H. Bulbulian and Thaddeus J. Litzow. *Proc., Staff Meetings Mayo Clinic*. Aug. 16, 1961. 36:17:429-438.

The practical advantage of collaborative efforts of the plastic surgeon and the maxillofacial prosthodontist in the reconstruction of auricular malformations is discussed. Three categories of malformations and the problems they present are described. The function of the tragus in relation to prosthetic restoration of the ear is emphasized. A recently devised procedure for constructing a tragus in its absence is noted. The minimal age at which prosthetic reconstruction should be undertaken is considered to be the early teens, when the patient enters high school. Other factors influencing the decision are considered.

# VOCATIONAL GUIDANCE

825. Dawson, M. M. L. (*Radcliffe Infirmary, Oxford, Eng.*)

Work assessment in some rehabilitation centres in U.S.A., 1958. *Occupational Ther.* July, 1961. 24:7:11-14.

A 1957-1958 visit to the U.S. afforded the author opportunity to compare various means used in assessing patients' fitness for return to work. Components of programs in 10 rehabilitation centers or hospitals are discussed. Centers visited included Bay State Rehabilitation Center, Boston; rehabilitation centers at Hartford, Conn., Rochester, N.Y., and St. Louis, Mo.; curative workshops of Racine and Milwaukee, Wis.; the Woodrow Wilson Rehabilitation Center, Fishersville, Va., the Institute for the Crippled and Disabled, New York City; Highland View Hospital, and the Vocational Guidance and Rehabilitation Services, both of Cleveland.

826. New York University. School of Education

*Proceedings of the conference on pre-vocational evaluation units and their use by state vocational rehabilitation*

*agencies in Region II . . . February 6-8, 1961, sponsored by . . . in co-operation with Office of Vocational Rehabilitation. . . . New York, The School, 1961. 51 p.*

Contents: An overview of pre-vocational unit evaluation programs, Anthony S. DeSimone.—Panel presentations: State vocational rehabilitation and pre-vocational evaluation units, Maurice J. Reisman; The state and private agency view of the role of the prevocational unit in the community, James N. Burrows; Developing a closer relationship between the state and private agency, Nathan M. Slater and Clare S. Spackman.—Summary of problem clinic reports.—Summary and recommendations of intrastate problem clinics.—Summary of conference, Salvatore G. DiMichael.

Participants included 20 prevocational unit personnel and 20 vocational rehabilitation agency staff members from New York, New Jersey, Pennsylvania, and Delaware.

A limited number of copies are available for distribution to agencies actively interested in the subject; requests should be sent to the Office of Vocational Rehabilitation, Washington 25, D. C.

See also 738; 739; 742.

# VOLUNTARY HEALTH AGENCIES

See 740.

# WORKMEN'S COMPENSATION—CALIFORNIA

827. California. State Department of Education. Vocational Rehabilitation Service

*The vocational rehabilitation of industrially injured workers; a report to the California Legislature prepared pursuant to Chapter 1738, Statutes of 1955. . . . Sacramento, The Dept., 1961. 177 p. figs., tabs., forms.*

The final report of a special study authorized in 1955 to determine need for vocational rehabilitation among industrially injured workers, methods of referral, and costs of providing services. Findings of the study and conclusions are summarized at the beginning of the report. The remainder of the publication discusses in detail the status of vocational rehabilitation under California workmen's compensation laws, design and procedures of the study, findings and statistical data, and problems in administration of services. Appendixes contain a list of definitions of terms used in tables and text, national breakdown by state of total vocational rehabilitations compared with industrially injured workers rehabilitated, data on characteristics of claimants accepted for rehabilitation, and statutory provisions made in various states for rehabilitation of the industrially injured.

(Continued from page 307)

agency, work does assume this central position and we concern ourselves with how a person responds to his supervisor, boss, coworkers, supervisees. We can measure, prepare, and help people to achieve against the reality goal of work. Development in a productive work role parallels psychological development.

Casework skill can be used more effectively if we accept vocational rehabilitation as a legitimate field for the social worker, if we examine more closely the socioeconomic factors in which we live, and if we perceive the work role as equal in importance to the family role in a person's capacity for healthful living.

## Events and Comments

### Vocational Problems of Deaf Women Studied in New York City

**A** TWO-YEAR RESEARCH STUDY "The Vocational Status, Adjustment and Problems of Deaf Women," supported in part by the U.S. Office of Vocational Rehabilitation, began on January 1 of this year. Seeking to identify the key problems met by deaf women who have worked or are working in the New York metropolitan area, the study will include intensive interview of 100 to 150 former pupils of the Lexington School for the Deaf, their employers, and their parents. Problems pertinent to vocational adjustment will be analyzed and recommendations on training and educating the deaf will be made.

Leo Connor, D.Ed., is project director and Paul Rotter, Ed.D., co-ordinator, the former being educational director of Lexington School, where the latter is assistant to the superintendent. Joseph Rosenstein, Ph.D., as research associate, will work full time on the project and will have charge of the interview questions and technics and analysis of results.

#### A Comment on

### A Rehabilitation Program For the Sexagenarian

**"A**FTER THREE YEARS of service to older disabled vocational rehabilitation clients, the following generalizations seem to emerge from this project:

"1) It is entirely feasible to offer a vocational rehabilitation program to clients 55 years of age and over. . . . Although it has been possible to place a large majority of these clients, at least half of the jobs obtained are short-term in nature. However, this is not altogether a negative factor in the program. Many older disabled clients welcome short-term employment. . . . On the other hand, some older disabled clients prefer full time year-round employment and, in many cases, achieve this goal.

"2) Although vocational evaluation and personal adjustment training are essential to the vocational rehabilitation process for these older disabled clients, a forceful dynamic placement program is the key to their ultimate employment. The statistics indicate that FECS [Federation Employment and Guidance Service] carries a heavy burden in the placement of these clients. It seems that other community resources do not place any substantial part of this population. . . .

"3) The sheltered workshop experience is a positive one for most of these older disabled clients, and contributes to their ultimate vocational rehabilitation. . . . It tends to stimulate their interest in employment, to maintain their morale while preparing for work, to improve their work habits, skills, and attitudes, and to provide opportunities

to measure themselves against the reality of a work setting. . . .

"4) Although this program serves clients with good mobility, it tends to offer little to the client who cannot regularly attend a central facility. . . . This finding suggests the need for specialized services for the more severely disabled older disabled client. . . .

"5) The experience derived in the FECS project suggests that there is much to be learned about the older disabled worker [e.g., 70 years of age or over]. . . . To this end, FECS is proposing, in conjunction with its suggested program for severely disabled older clients who cannot use the services of a central facility, a research program which will investigate more closely the underlying factors which determine the career patterns of members of this group. . . ."—*From Fourth Annual Progress Report: Demonstration of Feasibility of Vocational Rehabilitation for Vocationally Handicapped Persons 60 Years of Age and Over. July, 1961. 38 p. Mimeo. Federation Employment and Guidance Service, 42 E. 41st St., New York 17, N.Y.*

### Cofounder of PVA Dies

**J**OHAN M. PRICE, cofounder of the Paralyzed Veterans of America and of the National Paraplegia Foundation, died at his home in Stroudsburg, Pa., on July 31. He was 52 years of age. Mr. Price, a quadriplegic, founded the *Paraplegia News* in 1946 while a patient at the Bronx VA Hospital. Frank G. MacAloon (112 Franklin Ave., Fairview, N.J.) succeeds Mr. Price as editor.

### State Legislation Strengthens California's Program

**A** CO-ORDINATING COUNCIL on Programs for Handicapped Children was established by the California state legislature in their 1961 session by Assembly Bill 656, approved by Governor Edmund G. Brown. The Council is to be composed of the directors of the state departments of Education, Mental Hygiene, Public Health, and Social Welfare. The Council is directed to make a continuous review of programs and services offered by California state and local agencies to persons under age 21 who have physical and mental handicaps, to coordinate existing programs, and to report annually to the governor and the legislature recommending needed legislation.

Children suffering from cystic fibrosis and phenylketonuria have been specifically included under the crippled children's program (AB 480 and AB 1997). Free copies of these bills may be obtained from the Legislative Bill Room, State Capitol Building, Sacramento.

### New York City Housing Authority Reports on Programs for Elderly

**A** PARTMENTS ESPECIALLY DESIGNED for the elderly under the New York City Housing Authority (299 Broadway, New York 7, N.Y.), as of September, 1961, numbered 6,620, according to the Authority's chairman, William Reid. This includes 1,030 in operation; 5,590 are being constructed or planned, constituting 15.5 percent of a total of 36,165 apartments in the planning or construction stage under the over-all building program of the Authority.

Most of the apartments especially designed for the elderly are contained in housing developments serving other age groups. Developments are being planned for the exclusive use of older people, with other public and private developments having a cross section of age groups immediately adjacent.

The apartments for the elderly have non-skid tile bathroom floors, automatic shut-off devices on gas ranges, grab bars over bathtubs, easily opened windows, and larger radiators for higher temperatures in cold weather.

In operation are 20,042 conventionally designed two- and three-room apartments, the majority occupied by the elderly. The Authority has scheduled 5,295 apartments of the same type for completion in 2 or 3 years.

The Authority, in co-operation with public and private agencies, is sponsoring a program of community services for senior citizens, with an expanded number of golden-age clubs, special health maintenance clinics staffed with geriatrics specialists, and facilities for outdoor relaxation. Throughout the city 38 developments are now offering special community activities programs for the elderly.

### Director of HEW's Special Staff on Aging Takes Office

**D**ONALD P. KENT, Ph.D., formerly of the department of sociology, University of Connecticut, Storrs, Conn., as of September 1 became special assistant on aging to the Secretary of Health, Education, and Welfare and the director of the HEW Special Staff on Aging.

Dr. Kent, as director of the University's Institute of Gerontology and as chairman of the Connecticut Commission on Services for Elderly Persons, has had many contacts with federal agencies having programs affecting older persons and with the Staff he now heads. Dr. Kent also was a member of the National Advisory Committee for the White House Conference on Aging and of the planning committee for its Section on State Organization.

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